FM 8-42

COMBAT HEALTH SUPPORT IN STABILITY OPERATIONS AND SUPPORT OPERATIONS

HEADQUARTERS, DEPARTMENT OF THE ARMY

DISTRIBUTION RESTRICTION: Approved for public release; distribution is unlimited.

FIELD MANUAL
No. 8-42

HEADQUARTERS
DEPARTMENT OF THE ARMY
Washington, DC, 27 October 1997

COMBAT HEALTH SUPPORT IN STABILITY OPERATIONS AND SUPPORT OPERATIONS

TABLE OF CONTENTS

			Page
PREFACE			vii
CHAPTER	1.	COMBAT HEALTH SUPPORT PERSPECTIVE	1-1
	1-1.	General	1-1
	1-2.	Stability and Support Operations	1-1
	1-3.	Principles	1-2
	1-4.	Logistics Preparation of the Theater	1-4
	1-5.	Medical Threat Assessment	1-4
	1-6.	Foundations for Combat Health Support Programs	1-7
	1-7.	Command Surgeon	1-8
	1-8.	Command Surgeon's Role	1-10
	1-9.	Army Medical Department Battlefield Rules	1-12
	1-10.	The Law of Land Warfare	1-12
CHAPTER	2.	COMBAT HEALTH SUPPORT OPERATIONS	2-1
	2-1.	General	2-1
	2-2.	Planning and Preparing for Contingency Operations	2-1
	2-3.	Task Organization of Elements	2-2
	2-4.	Medical Evacuation Support	2-3
	2-5.	Patient Treatment, Stabilization, and Holding	2-4
	2-6.	Preventive Medicine	2-5
	2-7.	Combat Health Logistics	2-5
	2-8.	Veterinary Support	2-5
	2-9.	Combat Stress Control	2-6
CHAPTER	3.	COMBAT HEALTH SUPPORT TO STABILITY OPERATIONS AND SUPPORT OPERATIONS	3-1
	3-1.	General	3-1
	3-2.	Noncombatant Evacuation Operations	3-1
	3-3.	Domestic Support Operations	3-2

DISTRIBUTION RESTRICTION: Approved for public release; distribution unlimited.

*This publication supersedes FM 8-42, 4 December 1990.

			Page
	3-4.	Foreign Humanitarian Assistance	3-5
	3-5.	Security Assistance	3-7
	3-6.	Nation Assistance	3-7
	3-7.	Support to Counterdrug Operations	3-11
	3-8.	Combatting Terrorism	3-11
	3-9.	Peace Support Operations	3-14
	3-10.	Show of Force	3-17
	3-11.	Support for Insurgencies and Counterinsurgencies	3-17
	3-12.	Attacks and Raids	3-23
CHAPTER	**4.**	**SPECIFIC FUNCTIONAL AREA CONSIDERATIONS IN STABILITY OPERATIONS AND SUPPORT OPERATIONS**	4-1
Section	**I.**	**Command, Control, Communications, Computers, and Intelligence**	4-1
	4-1.	General	4-1
	4-2.	Considerations	4-1
Section	**II.**	**Patient Evacuation and Medical Regulating**	4-2
	4-3.	General	4-2
	4-4.	Patient Evacuation and Medical Regulating Support to Stability and Support Operations	4-2
Section	**III.**	**Hospitalization and Treatment**	4-4
	4-5.	General	4-4
	4-6.	Nonphysician Health Care Practitioners	4-4
	4-7.	Hospitalization and Medical Treatment in Support of Stability and Support Operations	4-6
Section	**IV.**	**Preventive Medicine**	4-9
	4-8.	General	4-9
	4-9.	Medical Threat	4-10
	4-10.	Preventive Medicine Support to Stability and Support Operations	4-12
Section	**V.**	**Veterinary Support**	4-16
	4-11.	General	4-16
	4-12.	Veterinary Support to Stability and Support Operations	4-17
Section	**VI.**	**Dental Support**	4-22
	4-13.	General	4-22
	4-14.	Dental Assessment	4-22
	4-15.	Dental Support to Stability and Support Operations	4-23
Section	**VII.**	**Combat Stress Control and Mental Health Services**	4-24
	4-16.	General	4-24
	4-17.	Combat Stress Control Support to Stability and Support Operations	4-25
Section	**VIII.**	**Combat Health Logistics**	4-27
	4-18.	General	4-27
	4-19.	Combat Health Logistics Support to Stability and Support Operations	4-27

Page

Section IX. Medical Laboratory Support 4-30
4-20. General 4-30
4-21. Medical Laboratory Support to Stability and Support Operations 4-31

APPENDIX A. ANTITERRORISM AND FORCE PROTECTION A-1
A-1. General A-1
A-2. Terrorism Considerations A-1
A-3. Estimate of the Situation for a Security Assessment A-1
A-4. Force Protection and Security Measures A-3

APPENDIX B. INTERAGENCY OPERATIONS B-1
B-1. General B-1
B-2. Unity of Effort B-1
B-3. Operations Within the United States B-1
B-4. Operations Outside the United States B-3
B-5. Military Effort B-4
B-6. Combat Health Support Implications in Interagency Operations B-5

APPENDIX C. RISK ASSESSMENT C-1
C-1. General C-1
C-2. Risk Assessment C-1
C-3. Rules of Risk Assessment C-1
C-4. Three-Tier Approach C-2
C-5. Levels of Risk C-3
C-6. Factors to Consider in Risk Assessment C-4

APPENDIX D. MULTINATIONAL OPERATIONS D-1
D-1. General D-1
D-2. Alliances and Coalitions D-1
D-3. Command Structure of Multinational Forces D-1
D-4. Rationalization, Standardization, and Interoperability D-3
D-5. Combat Health Support Issues D-5
D-6. Combat Health Support Considerations D-6

APPENDIX E. COMBAT HEALTH SUPPORT ASSESSMENT CHECKLIST E-1
E-1. General E-1
E-2. Sample Medical Assessment Checklist E-1

APPENDIX F. COMBAT HEALTH SUPPORT ASSESSMENT PLANNING FOR STABILITY OPERATIONS AND SUPPORT OPERATIONS F-1
Section I. Combat Health Support Estimate F-1
F-1. General F-1

			Page
	F-2.	Sample Format for the Combat Health Support Estimate	F-2
	F-3.	Sample Format for the Veterinary Estimate	F-11
	F-4.	Sample Format for the Preventive Medicine Estimate	F-17
	F-5.	Sample Format for the Dental Estimate	F-26
	F-6.	Sample Format for the Combat Stress Control Estimate	F-31
	F-7.	Sample Format for the Combat Health Logistics Estimate	F-37
Section	**II.**	**Combat Health Support Plan**	F-44
	F-8.	General	F-44
	F-9.	Sample Format for the Combat Health Support Plan	F-44
	F-10.	Sample Format for the Veterinary Service Portion of the Combat Health Support Plan	F-50
	F-11.	Sample Format for the Preventive Medicine Portion of the Combat Health Support Plan	F-51
	F-12.	Sample Format for the Dental Service Portion of the Combat Health Support Plan	F-53
	F-13.	Sample Format for the Combat Stress Control Portion of the Combat Health Support Plan	F-54
	F-14.	Sample Format for the Combat Health Logistics Portion of the Combat Health Support Plan	F-55
APPENDIX	**G.**	**NUCLEAR, BIOLOGICAL, AND CHEMICAL CONSIDERATIONS**	G-1
	G-1.	Threat	G-1
	G-2.	Biological Warfare Agents	G-1
	G-3.	Chemical Warfare Agents	G-2
	G-4.	Nuclear Weaponry	G-4
	G-5.	Operations Under Nuclear, Biological, and Chemical Conditions	G-4
	G-6.	Civilian Disasters	G-4
APPENDIX	**H.**	**SAMPLE CHECKLIST FOR DEPLOYMENT FOR COMBAT HEALTH SUPPORT OPERATIONS**	H-1
	H-1.	General	H-1
	H-2.	Sample Predeployment Checklist	H-1
APPENDIX	**I.**	**SPECIALTY RESPONSE TEAMS**	I-1
	I-1.	General	I-1
	I-2.	Responsibilities	I-1
	I-3.	Requests for Assistance	I-1
	I-4.	Team Composition and Specialty-Specific Equipment	I-2
	I-5.	Deployability and Continuous Operations	I-2
	I-6.	Administrative Support and Requirements	I-3
	I-7.	Equipment	I-4
	I-8.	Training	I-4

Page

I-9. Trauma/Critical Care Specialty Response Team I-5
I-10. Burn Specialty Response Team I-5
I-11. Preventive Medicine Threat Assessment Specialty Response Team I-6
I-12. Chemical/Biological Specialty Response Team I-7
I-13. Stress Management Specialty Response Team I-8
I-14. Telemedicine Specialty Response Team I-10
I-15. Food Safety, Veterinary Preventive Medicine, and Animal Health Care Specialty Response Team I-11

APPENDIX J. MASS CASUALTY SITUATIONS J-1
J-1. General J-1
J-2. Mass Casualty Management J-1
J-3. Triage Categories J-2
J-4. Control Element J-4
J-5. Establishing Triage, Treatment, and Holding Areas J-5
J-6. Medical Evacuation J-6
J-7. Disposition of Remains J-8

APPENDIX K. UNITED STATES DISASTER ASSISTANCE OPERATIONS K-1
K-1. General K-1
K-2. Administrative Support K-1
K-3. Priorities of Support K-2
K-4. Disaster Relief Task List and Status Board K-2

APPENDIX L. SELECTED SECTIONS OF TITLE 10, UNITED STATES CODE, PERTAINING TO HUMANITARIAN ASSISTANCE L-1
L-1. Humanitarian Assistance under Title 10, United States Code, Section 401 ..... L-1
L-2. Transportation for Humanitarian Relief Supplies under Title 10, United States Code, Section 402 ..... L-2
L-3. Foreign Disaster Assistance under Title 10, United States Code, Section 404 ..... L-3
L-4. Excess Nonlethal Supplies for Humanitarian Relief under Title 10, United States Code, Section 2547 ..... L-3
L-5. Humanitarian Assistance under Title 10, United States Code, Section 2551 ..... L-4

APPENDIX M. MEDICAL MISSION RECONNAISSANCE CHECKLIST M-1
M-1. General M-1
M-2. Sample Medical Mission Reconnaissance Checklist M-1

APPENDIX N. COMBAT HEALTH SUPPORT OF SPECIAL OPERATIONS FORCES N-1

Page

N-1. Special Operations N-1
N-2. Department of the Army Special Operations Forces N-1
N-3. The Threat to Special Operations Forces N-1
N-4. Special Operations Forces Missions N-2
N-5. Command and Control N-3
N-6. Army Special Operations N-3
N-7. Organic Combat Health Support Capability N-4
N-8. Planning for Combat Health Support of Special Operations Forces N-6
N-9. Patient Evacuation and Medical Regulating N-6
N-10. Hospitalization N-7
N-11. Combat Stress Control N-7
N-12. Preventive Medicine N-7
N-13. Medical Intelligence N-7
N-14. Veterinary Services N-8
N-15. Medical Laboratory Services. N-8
N-16. Combat Health Logistics and Blood Management N-8
N-17. Dental Services N-8
N-18. Interrelated Missions N-9
N-19. Unconventional Warfare N-9
N-20. Foreign Internal Defense N-9
N-21. Counterterrorism N-10
N-22. Direct Action N-11
N-23. Special Reconnaissance N-11

APPENDIX O. COMBAT STRESS CONTROL ACTIVITIES BY PHASE OF THE OPERATION O-1

APPENDIX P. DEVELOPMENT OF MEDICAL ELEMENT TACTICAL STANDING OPERATING PROCEDURES P-1
P-1. General P-1
P-2. Purpose of the Tactical Standing Operating Procedure P-1
P-3. Format for the Tactical Standing Operating Procedure P-2
P-4. Orientation of Newly Assigned Personnel P-3
P-5. Tactical Standing Operating Procedure (Sections) P-4
P-6. Tactical Standing Operating Procedure (Annexes) P-5

GLOSSARY Glossary-1

REFERENCES References-1

INDEX Index-1

PREFACE

This field manual (FM) establishes the combat health support (CHS) doctrine and provides the principles for providing CHS in stability operations and support operations. It is designed for use by personnel involved in CHS planning for stability operations and support operations and command surgeons (at all levels of command) and their staffs.

The proponent of this publication is the United States (US) Army Medical Department Center and School (AMEDDC&S). Send comments and recommendations on Department of the Army (DA) Form 2028 directly to the **Commander, AMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-6175.**

Unless this publication states otherwise, masculine nouns and pronouns do not refer exclusively to men.

Use of trade or brand names in this publication is for illustrative purposes only and does not imply endorsement by the Department of Defense (DOD).

CHAPTER 1

COMBAT HEALTH SUPPORT PERSPECTIVE

1-1. General

Although the Army's primary focus is to fight and win our nation's wars, it is often employed in stability and support operations. In stability and support operations, the Army executes missions in both peace and conflict: what combat does occur is limited to the minimum necessary to support the political objectives. The primary recipients of combat service support (CSS) in stability and support operations are likely to be civilians (US or foreign), rather than US combat forces as in war. The CHS planner must be capable of adapting traditional methods of health care delivery, leveraging technology, and establishing new procedures to meet the challenges presented.

1-2. Stability and Support Operations

a. Stability and support operations are conducted in the political-military environments of peace and conflict. In both, the role of the Armed Forces is to aid in the protection and promotion of national objectives without resort to war. Conflict is distinguished from peace by the introduction of organized political violence. Yet, it is a situation that remains amenable to solution by political means with military support. In peacetime, the Army prepares for war and effects deterrence by its demonstrated capabilities. In addition, military resources are used in peacetime as a matter of economy in government. Stability and support operations can include—

- Noncombatant evacuation operations (NEO).
- Foreign humanitarian assistance and disaster relief.
- Combatting terrorism (counterterrorism and antiterrorism [Appendix A]).
- Nation assistance.
- Security assistance.
- Support to counterdrug operations.
- Support to counterinsurgencies.
- Arms control and disarmament.
- Domestic support operations, to include domestic humanitarian assistance and emergency services.
- Peace operations.
- Support to insurgencies.

- Shows of force and demonstrations.
- Strikes and raids.

b. In stability and support operations, the provision of CHS and health education plays a more direct role in countering both the medical and general threats. Combat health support in stability and support operations can be defined as those actions encompassing all military health-related activities taken or programs established to further US national goals, objectives, and missions. These actions and programs may differ to some degree from the traditional CHS role (delivery of quality health care) of the Army Medical Department (AMEDD) in war. For example, these CHS operations can play a significant and proactive role in nation assistance by—

- Assisting with the development and refinement of the host-nation (HN) medical infrastructure.
- Providing and maintaining the basic necessities of life for the general population through HN civilian medical programs.
- Providing assistance in establishing, repairing, or improving basic health and sanitation services.

1-3. Principles

a. The principles of war apply in stability and support operations, although they may require adaptation to meet the challenges presented (refer to FM 100-5 for an in-depth discussion of these principles). A number of principles that guide actions within the stability and support operations arena are also well established. These principles are—

(1) *Objective.* The CHS commander directs every CHS operation towards a clearly defined, decisive, and attainable objective. The military effort must be integrated with the total effort in achieving the strategic aims and culminating in the desired end state. The CHS commander must—

- Understand the strategic, operational, and tactical aims.
- Set appropriate objectives.
- Execute the CHS mission.

(2) *Unity of effort.* The CHS commander must seek unity of effort toward every objective. In stability and support operations, the problems requiring military action are so complex and of such magnitude that no single agency can overcome them. Further, it is important that the participating agencies (Appendix B) work toward the same purposes. The unified efforts of all participants are required. Planning must address the military contribution to stability and support operational initiatives that are political, economical, psychological, and military in nature. The other participants may include—

- Other Services.
- United States governmental agencies.
- Allies.
- Coalition partners.
- Host nation.
- Nongovernmental organizations (NGOs).
- Private volunteer organizations (PVOs).
- Religious groups.

(3) *Legitimacy*.

(*a*) Legitimacy involves sustaining the people's willingness to accept the right of the government to govern or of a group or agency to make and carry out decisions. (For example, in counterinsurgency operations, CHS programs and initiatives must not undermine the confidence people have in their nation's government. Combat health support operations must compliment, not detract from, the legitimate authority of a HN government.)

(*b*) United States military forces are also concerned with the legitimacy issue when involved with foreign intervention. Combat health support, due to its acceptance by the civilian population, can assist in mitigating the adverse impact that other US military interventions may cause in the region.

(4) *Perseverance*. In stability and support operations, strategic goals may be accomplished by long-term involvement, plans, and programs. Short-duration operations will occur, but these operations must also be viewed as to their impact on the long-term strategic goals. Therefore, the CHS planner must prepare for the measured, protracted application of the military CHS capability to support the strategic goals and work toward the desired end state.

(5) *Restraint*. Stability and support operations place constraints on the potential actions that can be accomplished and the rules of engagement (ROE) governing these actions. Imprudent action outside the ROE may, in fact, have a detrimental effect on the attainment of strategic goals and objectives. All forces participating in stability and support operations, therefore, must incorporate restraint and adherence to established laws, regulations, policies, and norms to ensure the furtherance of the military objectives.

(6) *Security*. The security of US forces abroad is paramount. Commanders and planners must be aware of the ever-present danger that can exist from various groups, factions, or other governments. Commanders must continually perform risk assessments to ensure the safety of all operations (Appendix C). Even in a peacetime environment, US military forces can be targeted for terrorist activities. The commander must ensure that his forces remain vigilant, implement active and passive security measures, and can

transition from a peacetime operation to a combat response, if required. (For example, CHS planners must ensure the capability exists to transition from humanitarian activities to the traditional support of conventional forces engaged in combat.) Further, CHS personnel must be prepared to defend themselves and their patients should the need arise.

b. Especially in stability and support operations, the political arena within which missions are to be accomplished is of considerable importance. As in all military operations, political objectives drive decisions at the strategic level. While the individual operator need not be driven by political motives, it is important for the leadership to recognize the importance of political objectives in planning and executing the mission.

1-4. Logistics Preparation of the Theater

a. Logistics preparation of the theater is a systematic approach for planning for the logistics (force structure, resources, and strategic lift) needed to support the commander's plan. This process focuses on identifying the resources currently available in the theater of operations (TO) for use by friendly forces and ensuring access to them. These planning actions include—

- Identifying and preparing bases of operations.
- Selecting and improving lines of communications (LOC).
- Projecting and preparing forward logistics bases.
- Forecasting and building operational stock assets forward and afloat (FM 100-17-1).

b. This process is essential to ensure that sufficient CHS resources are allocated and correctly distributed within the TO. In stability and support operations, where brigade-sized or smaller organizations may enter the TO first, the only logistics available to them may be what they bring with them. In the CHS arena, contracting for HN support may not be possible as quality assurance standards are stringently enforced. Further, our medical equipment and repair parts may be beyond the technology available in the HN.

c. Stability and support operational missions will be joint or multinational (Appendix D) in nature. The CHS planner must include the availability of resources of the other Services, the HN, and other participating nations, agencies, and organizations within the TO. This ensures that the employment of the resources available are maximized and that a duplication of services does not occur.

1-5. Medical Threat Assessment

a. A critical element of the CHS assessment is a thorough appraisal of the medical threat. This assessment includes the medical threat to the deploying forces and to the residents in the area of operations (AO). The US soldier is placed at more risk in stability and support operational scenarios as the incidence

and exposure to infectious diseases and environmental hazards are greater in man-made or natural disaster areas and in developing nations. The medical threat is derived through established intelligence channels and from a variety of informational sources outside the military.

b. The ability to obtain, interpret, and use medical intelligence is critical to the success of the CHS mission. Regardless of whether the operation is conducted within the US or abroad, man-made and natural disasters can cause a resurgence of diseases once thought to be at low epidemiological levels and may also result in environmental contamination. A combination of factors can result in the spread of communicable diseases in epidemic proportions and increased opportunity for exposure to nuclear, biological or chemical (NBC) hazards. These factors are—

- Disruption of sanitation services (such as garbage disposal or sewer systems).
- Contamination of food and water.
- Development of new breeding grounds for rodents and arthropods (such as in rubble or in stagnant pools of water).
- Disruption of industrial operations.
- Dispersion of biological or radiological waste by improper handling or terrorist activity.

(1) Medical intelligence is the product resulting from the collection, evaluation, analysis, integration, and interpretation of all available general health and bioscientific information. Medical intelligence is concerned with one or more of the medical aspects of foreign nations or the AO and which is significant to CHS (Appendix E) or general military planning. Until medical information is processed, it is not considered to be medical intelligence. Medical information pertaining to foreign nations is processed by the Armed Forces Medical Intelligence Center (AFMIC). Medical threat information in AOs within the US can be obtained from—

- The United States Army Medical Command (USAMEDCOM).
- United States Army Medical Department medical centers (MEDCENs) and medical department activities (MEDDACs) within the immediate area.
- The United States Civil Affairs (CA) and Psychological Operations Command.
- Local public health officials.
- The American Public Health Association (FM 8-33).
- The Centers for Disease Control.

(2) The special training of preventive medicine (PVNTMED) personnel, as well as other medical professionals, is used to provide a clear assessment of the medical threat. Preventive medicine personnel are specifically trained and equipped to collect, analyze, and interpret health information. When

the assessment includes oral, dental, or maxillofacial considerations, the dental public health officer has similar specialized training in his field. The veterinary PVNTMED officer can provide expertise in the public health ramifications of zoonotic diseases and biological warfare (BW) and chemical warfare (CW) agents. These personnel can make recommendations for types of activities to be accomplished and their priority for support. Using these skills maximizes the efficient use of limited CHS resources. For consultation purposes during the assessment, the medical personnel conducting the assessment should have free access to all medical professionals within the CHS force and the local medical community.

c. Combat health support planners must acquaint themselves with the currently existing intelligence products. These products include national-level intelligence products such as the Medical Capabilities Studies and Disease Occurrence Worldwide. These reports are specifically produced to support US military CHS operations conducted outside the continental United States (OCONUS). These reports can be obtained through operational and medical intelligence channels (such as the medical brigade S2 [Intelligence Officer, US Army] or the corps surgeon's office). (Refer to FM 8-10-8 for specific information.)

d. As CHS plans (Appendix F) and operations progress, the requirements for additional medical intelligence will occur. All such requirements should be requested through intelligence channels as soon as they are validated; when required, coordination should be effected with local agencies.

e. In OCONUS operations, the CHS planner must make himself aware of the medical threat posed by the disaster (such as continued flooding, earthquakes and aftershocks, or further explosions) and groups, factions, opponents, terrorists, or enemy forces operating within the AO. This threat also includes the potential use and capabilities of weapons systems and munitions, such as NBC (Appendix G), directed-energy (DE) weapons or devices, or conventional armaments, and the potential for terrorist attacks or incidents, including the use of CW and BW agents without weapons delivery systems. Combat health support planning and force survivability necessitate that CHS units remain abreast of the complete intelligence picture.

f. The medical threat includes the stress threat. The stress threat encompasses all stressors in the environment that are likely to threaten the mission and the soldier's current and future well-being. The stress threat can result in—

- Misconduct stress behaviors.
- Post-traumatic stress disorder.
- Battle (conflict) fatigue (BF).
- Neuropsychiatric (NP) disorders, including organic mental disorders.

g. Should CHS personnel gain information of potential medical intelligence value while in the performance of their duties, they are required to report it to their supporting intelligence element (FM 8-10-8).

h. For additional information on infectious diseases and their prevalence, refer to FM 8-33.

i. For additional information on the medical threat and intelligence preparation of the battlefield, refer to FM 8-10-8 and FM 8-55.

1-6. Foundations for Combat Health Support Programs

a. The cornerstones of CHS in stability and support operations are determined by the specific mission but can include—

- Planning for and providing direct health services to US, allied, coalition, and HN military forces and, when authorized, US government employees, civilian contractors, and United Nations (UN) personnel.

- Planning for and providing PVNTMED and veterinary services to HN and civilian populations.

- Providing humanitarian care and assistance to disaster victims.

- Enhancing readiness by real-time, hands-on training. (This training is conducted in an unfamiliar venue, involving diseases not normally widespread in the US or which are normally at low epidemiological levels. These missions are conducted in varying public health conditions.)

- Promoting and enhancing the growth potential of a HN medical infrastructure.

- Planning for and developing programs which provide direct patient care support for both HN military and civilian populations.

- Planning for and providing health education and CHS training for HN or US-backed military or paramilitary forces.

- Providing traditional CHS to conventional and unconventional forces to ensure the rapid return to duty (RTD) of trained manpower.

b. The CHS commanders and planners must exercise flexibility and initiative to enhance the potential for success of the CHS mission and to further national strategies.

c. Although the missions assigned to medical units may be classified under general activities (such as disaster relief, support for counterinsurgency operations, or support to counterdrug operations), each will be unique to its specific situation. The unique setting for each stability and support operational mission is dependent upon—

- Type of operation.

- Level of hostilities.

- Duration of the operation.
- Rules of engagement.
- Political climate.
- Economic status.
- Cultural influences and biases.
- Religious preferences.
- Other socioeconomic considerations.

Combat health support commanders and planners must recognize these influences, determine their significance, and incorporate them into the planning and decision-making process.

1-7. Command Surgeon

a. The command surgeon is instrumental in planning, developing, and implementing CHS programs. Due to the necessity to task organize the forces employed in stability and support operations and established troop ceilings for operations, the number of medical personnel employed may be limited. In many cases, the CHS commander is dual-hatted as the command surgeon.

b. The duties and responsibilities of the command surgeon include—

- Determining requirements and providing oversight for—
  - Requisition, procurement, storage, maintenance, distribution management, and documentation of combat health logistics (CHL), to include blood management.
  - Combat health support personnel.
  - Financial management of resources allocated and expended.
- Planning and coordinating transportation requirements in excess of organic capability.
- Planning and coordinating with the CHS commanders, task force (TF) commanders, or other elements, units, or agencies for continuous CHS.
- Submitting to higher headquarters those recommendations on professional medical problems that require research and development. (In developing nations, this responsibility takes on added significance as unfamiliar diseases may be encountered.)

- Recommending uses of captured (or abandoned) Class VIII or locally available medical supplies in support of detainees, enemy prisoners of war (EPW), HN personnel, and other recipients.

- Advising on the—

  - Health of the command.

  - Combat health support resources available within the AO.

  - Medical effects of the environment and of NBC or DE weapons systems and devices on personnel, Class VIII materiel, rations, and water.

  - Medical intelligence requirements.

- Planning and coordinating (internally and externally) the following CHS operations:

  - Medical evacuation by US Air Force (USAF) or US Navy (USN) resources or resources from the civilian community, HN, allies, or coalition partners.

  - Medical treatment to include hospitalization in medical treatment facilities (MTFs) established by the other Services, allies, coalition forces, or HN. (This includes MTFs afloat.)

  - Dental services. (The senior dental officer assigned serves as the command dental surgeon for the purpose of coordinating dental activities for the command surgeon.)

  - Veterinary food inspection, animal care, veterinary PVNTMED activities of the command, and civic assistance programs within the local community.

  - Preventive medicine services.

  - Nursing services.

  - Medical laboratory services.

  - Humanitarian assistance and disaster relief programs.

  - Mental health (MH) and combat stress control (CSC) programs.

  - Rehabilitation support.

  - Nutrition care services.

  - Combat health support aspects of rear area protection.

  - Recommendations on the assignment and/or attachment of medical units and/or personnel.

- Combat health support assessments, estimates, and plans.

1-8. Command Surgeon's Role

The command surgeon's role includes the duties and responsibilities specified in paragraph 1-7. The elements of assessing, problem solving, planning, and coordinating programs takes on an added significance in stability and support operations.

a. Assessing.

(1) Combat health support assessments must be carefully and comprehensively completed. They need to include such areas as—

- Health status of population groups (such as disaster victims or HN's military).
- Potential medical threat under various operational scenarios.
- Availability of CHS resources from all sources.

(2) In operations conducted OCONUS, US assistance should only be provided when all resources of the requesting state are exhausted or overwhelmed.

(3) Current and timely medical intelligence and information (paragraph 1-5) is an important aspect in preparing a comprehensive CHS assessment (Appendix E).

(4) Updated assessments should be maintained on each specific country or geographical area within the commander's AO.

b. Problem Solving. Due to the uniqueness of the stability and support operational missions, planning for potential scenarios requires initiative, flexibility, versatility, and improvisation to successfully complete established missions. As CHS planners, command surgeons must not become inflexible in their thinking or rely solely on the traditional methods of CHS delivery. Combat health support planners must explore all potential alternative courses of action (COAs). They must also be prepared to deal with unanticipated occurrences. As CHS resources are scarce, the CHS planner must maximize their effective use to ensure adequate health care regardless of the scenario.

c. Planning.

(1) Involvement early in the planning process and inclusion on the advance party assists in ensuring that—

- Adequate CHS assets are available.

- Requirements that cannot be met by the available CHS resources are identified and action is taken to correct the deficiencies noted.

- An accurate assessment of the medical threat is made and measures to counter this threat are implemented.

(2) Stability and support operations require coordinated actions with other US and foreign military forces and both private and public civilian agencies.

d. Coordinating.

(1) The conduct of CHS in stability and support operations requires thorough coordination prior to implementation. This coordination ensures that—

- Duplication of services and/or missions does not occur.

- The mission is executed properly.

- Interoperability exists between the Services and other participating agencies/nations in areas such as communications.

- Adequate CSS resources are allocated for the mission. This includes all classes of supply and the means to resupply the operation.

- Scarce resources are used effectively and efficiently.

- Operations security (OPSEC) is not compromised.

(2) In stability and support operations, coordination is not limited only to the military forces operating within the AO, but extends to all other participants.

(3) Thorough coordination during the planning process ensures that the final plan—

- Contributes to the accomplishment of the desired end state.

- Satisfies the requirements of the civil authorities or the HN.

- Can be accomplished with the resources available.

- Provides a favorable climate for the acceptance of the government program by the targeted population.

- Does not bypass or discourage the full application of all local or HN resources to the situation.

1-9. Army Medical Department Battlefield Rules

a. The AMEDD Battlefield Rules define the focus of the CHS system in both war and stability and support operations. These Battlefield Rules in order of precedence are to—

- Maintain a presence with the soldier (being there).
- Maintain the health of the command.
- Save lives.
- Clear the battlefield.
- Provide state-of-the-art care.
- Ensure the early RTD of sick, injured, or wounded soldiers.

b. In stability and support operations, PVNTMED plays an important role in the focus of health care delivery, as the major cause of soldier noneffectiveness in this environment is disease and nonbattle injuries (DNBI). In many situations, CHS personnel will arrive in the AO before combat and combat support (CS) troops. Effective measures to counter the medical threat will reduce the number of soldiers who become ill from endemic diseases (morbidity and mortality rates) and will enhance the ability to rapidly return soldiers to duty once stricken by disease. Combat stress control will also reduce DNBI and stress casualties and promote mission effectiveness. During conflicts and contingency operations, wounded soldiers are quickly evacuated from the battlefield to established MTFs within the AO, or provided evacuation to the continental United States (CONUS) or another designated support base. During Operation Just Cause, wounded soldiers were stabilized at MTFs established at the airfield and immediately evacuated to Brooke Army Medical Center and Wilford Hall Medical Center in San Antonio, Texas, for definitive and restorative care. The care provided our forces is as sophisticated as possible in the immediate AO with comprehensive and definitive care available in the support base. Rapid medical evacuation with the provision of en route medical care enables the patient to be cared for during evacuation to the destination MTF.

1-10. The Law of Land Warfare

a. The conduct of armed hostilities on land is regulated by the Law of Land Warfare. This body of law is inspired by the desire to diminish the evils of war by—

- Protecting both combatants and noncombatants from unnecessary suffering.
- Safeguarding certain fundamental human rights of persons who fall into the hands of the enemy, particularly prisoners of war, the wounded and sick, and civilians.
- Facilitating the restoration of peace.

b. The law of war is derived from two principal sources—

(1) Treaties (or conventions) such as the Hague and Geneva Conventions.

(2) Customs which are practices that by common consent and long-established uniform adherence have taken on the force of law.

c. Under the US Constitution, treaties constitute part of the Supreme Law of the Land, and thus must be observed by both military and civilian personnel. The unwritten or customary law of war is also part of the law of the US. It is binding upon the US, citizens of the US, and other persons serving this country.

d. Combat health support commanders must ensure that they operate within the confines of the Law of Land Warfare. Additionally, in stability and support operations, questions concerning eligibility of beneficiaries, sources of funding, ROE, and other legal issues will be encountered. Combat health support commanders must ensure that they receive adequate and timely legal advice prior to implementing programs or executing missions. Due to the increased visibility to the news media that these operations attract, CHS commanders must also ensure their actions do not provide an impression of impropriety in the execution of their duties.

e. For additional information on the Law of Land Warfare, refer to FM 27-10.

CHAPTER 2

COMBAT HEALTH SUPPORT OPERATIONS

2-1. General

a. Combat health support provides the capability to prevent DNBI and to collect, triage, treat, and evacuate or RTD sick, injured, or wounded soldiers. The AMEDD objective of conserving the fighting strength faces one of its greatest challenges in stability and support operations. This chapter discusses many of the aspects of providing traditional CHS and the factors that influence its delivery in stability and support operational scenarios.

b. Each stability and support operational mission is unique to the geographical area, the mix of forces, and the objectives of the operation. Due to this fact, the CHS planner must—

- Be included early in the mission planning process.
- Remain flexible to accommodate last minute requirements.
- Remain receptive to new and innovative methods of providing the required support.
- Ensure that thorough coordination is accomplished on all aspects of the operation.

2-2. Planning and Preparing for Contingency Operations

a. In stability and support operations, many of the missions assigned to US Army forces will be received as short-notice deployments. The advance preparation time will be limited. Further, due to the sensitivity or the OPSEC level of the operation, the number of individuals engaged in the planning process may also be restricted. It is, therefore, necessary for the CHS commander to ensure that his unit is administratively ready for a short-notice deployment (Appendix H). He can accomplish this by ensuring that—

- Unit personnel have all required immunizations; that the dental status of the command is monitored; and that any personnel actions stemming from medical conditions (such as military occupation specialty [MOS] reclassification based on physical profile) are expeditiously processed.

- Based on operation plans (OPLANs) and contingency plans, special clothing, equipment, or supplies required for the AO are on hand and in a serviceable condition. For example, if the potential AO is in mountainous terrain, equipment such as pitons, piton hammers, and extra ropes may be required. Depending upon the climate, additional heavy clothing (winter parkas) may be needed to operate at high altitudes. Other supplies and equipment that might be required include sunscreen and sunglasses to combat the effects of bright sunlight. On the other hand, operations in tropical jungles require items such as lightweight jungle fatigues, arthropod netting, insect repellent, and aerosol insecticides, as well as sunscreen and sunglasses.

- Updated medical intelligence on the medical threat in the proposed AO is maintained. This information is vital to ensure that the appropriate immunizations are provided; that any chemoprophylaxis that may be required (such as for malaria) is on hand or obtainable on short notice; and

that effective PVNTMED measures (PMM) are planned for and implemented to counter the specific medical threat. For example, in Operation Urgent Fury, US forces were not familiar with the vegetation indigenous to the area. Some troops began to present with large blisters on their bodies after conducting sweeps of jungle areas and underbrush. This condition initially led to speculation that a CW agent which burned and blistered the skin and damaged the respiratory system might be in use in the AO. The cause of the blistering was determined to be, however, the sap of the manchineel tree. Had the troops been forewarned of the effect of the sap, they would have been better able to protect themselves against injury.

- Soldier stress related to family issues can be reduced by integrating unit families into an active family support group network and by briefing families on the unit mission if OPSEC permits. To enhance readiness, family care plans should be kept up to date.

- Since operations in stability and support operations will normally be joint or combined in nature, it is important that CHS personnel be familiar with the other Services' equipment and procedures. Early and continuous coordination among command surgeons will facilitate this process. For example, if the USAF is providing all of the medical evacuation support or if the USN is providing Echelon III hospitalization afloat, the US Army personnel participating should know how to load and unload patients on the other Services aircraft and ships. During Operation Urgent Fury, problems were experienced with communications between US Army air ambulances and a USN hospital ship. Also, many medical evacuation pilots did not have the appropriate deck-landing certification required to land on a ship. These situations presented difficulties which could easily have been avoided with the proper coordination and familiarization training.

b. To enhance mission success, planning must be thorough, and the plan must be rehearsed. A rehearsal is the process of practicing a plan before its actual execution. Rehearsing key actions allows participants to become familiar with the operation and to visualize the plan. Rehearsals take on an added importance in stability and support operations to ensure synchronization and interoperability among the various participants.

c. A rapid response capability is often needed to mobilize assets to assess what support is required in the event of a disaster or other serious incident. The USAMEDCOM has developed specialty response teams (SRTs) within their table of distribution and allowances (TDA) organization. Refer to Appendix I for further information.

2-3. Task Organization of Elements

a. Forces used for providing CHS to contingency operations will often be task-organized to accomplish the mission. In a mature theater, there are four echelons of medical care. Each echelon of care incorporates the capabilities of the lower echelon plus enhancing and expanding on that care. Echelon I care is provided by the combat medic (assisted by the administration of first aid by nonmedical soldiers [self-aid, buddy aid, and combat lifesaver]) and the battalion aid station (BAS). The care provided consists of emergency medical treatment (EMT), advanced trauma management (ATM), and those procedures necessary to stabilize a patient for further evacuation (to include early surgical intervention for nontransportable patients) or to return the soldier to duty. Echelon II care is provided by the forward support medical company (FSMC), the main support medical company (MSMC), the area support medical

company (ASMC), and the medical companies/troops of separate brigades and armored cavalry regiments. This echelon of care has a 72-hour holding capability for those patients who can RTD within that time. Echelon II can be augmented by the forward surgical team (FST) to provide surgical intervention within the division area. The theater hospitalization system (Medical Force 2000) is encompassed by Echelon III (combat support hospital [CSH]) and Echelon IV (field hospital [FH] and general hospital [GH]). Under the medical reengineering initiative (MRI) there will be only one hospital in corps and echelons above corps. (For an in-depth discussion of the echelons of medical care, refer to FM 8-10.)

b. In stability and support operations, this full array of medical units may not be in place to provide the required care and to perform the administrative support needed to coordinate patient evacuation, care, and treatment.

c. There is no specific table of organization and equipment (TOE) medical unit which is designed to solely operate in stability and support operations. Rather, during the planning process, it is determined what CHS assets will be required to support the operation. This support is then task-organized from existing units designated to provide CHS for the operation. This type of tailoring of the CHS package for the support of the mission necessitates the early involvement of the CHS planner. If the CHS planner is not included early in the process, the required support may not be tailored to maximize the effective use of limited CHS resources.

2-4. Medical Evacuation Support

a. Evacuation Policy. With a force projection Army the evacuation policy for the AO may only be a matter of hours or days. Soldiers who are wounded, injured, or ill and who cannot be rapidly returned to duty are evacuated to MTFs in a support base outside of the AO or to CONUS. The CHS planners should determine what the evacuation policy will be, and in cases where it is compressed, build the necessary evacuation platforms into the plan. An adequate treatment capability must also be included in the plan to ensure that patients are sufficiently stabilized to withstand the evacuation. The evacuation policy in stability and support operations may be governed by such factors as the—

- Short duration of the operation.
- Inadvisability of building a large military base structure in the AO where the US presence is intended to display a low profile.
- Troop ceiling established for the operation.
- Anticipated patient work load.
- Anticipated level of hostilities.
- Availability of HN support.

b. Coordination. In the mature theater, medical evacuation support is provided by the echelon of care to which the patient is being evacuated. In stability and support operations, medical evacuation support

may not follow the traditional patient flow means (FM 8-10-6). It may also require a longer lead time for coordination of issues, such as—

- Using civilian controlled air space.
- Crossing national borders.
- Obtaining route approval.

c. United States Air Force Support. A task-organized Echelon II medical unit may be required to coordinate for medical evacuation and medical regulating support directly with the USAF. (In the mature theater, this is normally accomplished by Echelons III and IV MTFs, and the medical brigade, or command medical regulating offices [MROs], Theater Patient Movement Requirements Center [TPMRC], and USAF liaison elements.) The administrative burden for preparation of the required forms for entering the patient into the USAF patient evacuation system is the responsibility of the originating medical facility (OMF) which, in this case, is the Echelon II MTF. The preparation of Department of Defense (DD) Form 600, Patient Baggage Tag, DD Form 601, Patient Evacuation Manifest, and DD Form 602, Patient Evacuation Tag, is normally not done at this echelon, nor does the unit routinely stock these forms. It is, therefore, important for the CHS commander to anticipate this requirement. The unit should have the necessary forms on hand and should have conducted training on their preparation, if required. (For information on the completion of these forms, refer to FM 8-10-6.)

d. United States Navy Support. The USN may also provide medical evacuation, treatment, and hospitalization support during the operation. The CHS commander must ensure that coordination on communications requirements and capabilities and the availability of services is accomplished. Without affecting the required coordination, it may not be possible for US Army elements to communicate effectively with the USN element providing the support.

e. Evacuation Responsibility. Depending on the scenario and resources available, the doctrinal method of the higher echelon of care evacuating patients from the lower echelon may not be possible. The CHS planner must ensure that the medical evacuation support planned is sufficiently flexible to adapt to the realities of the situation. For example, depending upon the CHS resources deployed, air ambulance assets may have to be attached to an Echelon II MTF. To ensure adequate support can be obtained and to sustain the air ambulances, coordination for fuel, aviation maintenance (both unit and intermediate), and Army airspace command and control (A2C2) must be accomplished. Additionally, the CHS commander will need to familiarize himself with requirements for crew endurance, aircrew training programs, aircraft capabilities, and flight surgeon support. The stated evacuation policy for the operation will influence the task organization for the mission. It will also dictate the number of evacuation platforms required to perform the mission efficiently. A short evacuation policy requires that the number of air and ground ambulances, as well as USAF aeromedical evacuation resources, be increased for the mission.

2-5. Patient Treatment, Stabilization, and Holding

During the initial phase of the operation, medical evacuation support may not be available. The CHS commander must include in his planning the possibility that he may be required to hold seriously injured or

wounded patients for a number of hours or perhaps even days. Faced with this requirement, the CHS commander may have to include a task-organized surgical capability to stabilize these patients sufficiently to withstand the delay in evacuation or he may be required to increase his capability to hold, treat, and care for patients. During this period, the only evacuation means may be by vehicles/aircraft of opportunity. If this situation is planned for, the CHS commander may be able to provide en route medical care for the most seriously injured on these backhaul missions.

2-6. Preventive Medicine

Disease and nonbattle injuries have in past wars exceeded the number of soldiers who were wounded in action (WIA). This is especially true in stability and support operations. The combined effects of endemic and epidemic diseases, soldiers not acclimatized to the environmental conditions, poor sanitation, increased exposure to disease vectors and environmental contamination, and foodborne and waterborne diseases may have a catastrophic effect on mission accomplishment. All commanders must be prepared to counter the medical threat through command emphasis on water discipline programs, physical training, immunization/ chemoprophylaxis, personal hygiene, and field sanitation. Field sanitation teams are the eyes of the commander; therefore, they must maintain close coordination and must accurately report on any potential medical threats. The CHS commander must not only be concerned with these activities for his own unit but also for the command as a whole. He must ensure that he has an aggressive pest management program and that dining facilities are inspected. He must also ensure that all supported company-sized or larger units have on hand all authorized unit-level PVNTMED equipment and supplies. For additional information on PVNTMED issues, refer to Chapter 4 of this manual, Army Regulation (AR) 40-5, FM 21-10, and FM 21-10-1.

2-7. Combat Health Logistics

a. In stability and support operations, a medical logistics battalion (forward or rear) may not be available within the AO. Coordination for Class VIII supply/resupply, medical equipment maintenance, eyewear fabrication, and blood management takes on an added importance in stability and support operations. Prior to the operation, the number of days of supply which the in-country CHS organizations will require is determined. A critical items list of supplies which will be in high demand is also prepared. Pre-configured push packages must be developed to maintain appropriate stockage levels in-country until CHL elements enter the theater, become operational, and line order requisitioning procedures can be instituted.

b. When deployed in joint operations, the medical logistics battalion may be designated as the single integrated medical logistics manager (SIMLM) for the mission.

c. For additional information on CHL, refer to Chapter 4 of this manual and FM 8-10-9.

2-8. Veterinary Support

a. Department of Defense Veterinary Support. Department of Defense (DOD) veterinary support in stability and support operations entails the equitable distribution of veterinary support in the areas of food safety surveillance and animal health care to all military services.

b. Planning Factors. The CHS planner must determine the feeding policy, extent of local food procurement, type of available food storage facilities, zoonotic disease threat to US forces, and required health care support for deployed military working dogs (MWD), other government-owned animals, and military mascots.

c. Veterinary Support Packages. Veterinary support packages can be tailored to respond to either food safety surveillance or animal health care missions in the planning process. For additional information, refer to Chapter 4 of this manual and FM 8-55.

2-9. Combat Stress Control

Predeployment training on stress identification and control and command emphasis on stress-related issues will assist in maintaining positive mission focus and in reducing the number of stress casualties and stress-induced misconduct during an operation. The environments in which many stability and support operations occur can induce stress through feelings of loneliness, boredom, and alienation due to cultural and language differences. Some stability and support operations expose soldiers to personal danger, to the injury of other unit personnel, or to injustices, suffering, or death of innocent people. Changing mission objectives and ambiguous ROE can add greatly to the stress of the situation. Command emphasis should be placed on ensuring control measures are implemented by unit commanders and their troop leaders. Where feasible and within the limits of the troop ceiling, the CHS plan should provide a 1- to 3-day medical holding capability for acute stress casualties. This facility can be austere. For additional information, refer to Chapter 4, and to FM 8-51 and FM 22-51.

CHAPTER 3

COMBAT HEALTH SUPPORT TO STABILITY OPERATIONS AND SUPPORT OPERATIONS

3-1. General

Commanders are used to thinking about changes in the direction and depth of the battle and adjusting battle plans to achieve objectives. Stability and support operations require attention to factors which may be absent in war. The political dimension lies at the core of stability and support operations. The objective of these operations is to support a political resolution of problems affecting US national interests.

3-2. Noncombatant Evacuation Operations

a. Noncombatant evacuation operations are conducted to evacuate civilian noncombatants and nonessential military personnel from locations in a foreign (host) nation during time of endangerment to a designated safe haven. These operations are normally conducted to evacuate US citizens whose lives are in danger from a hostile environment or natural disaster. They may also include the evacuation of US military personnel and dependents, selected citizens of a HN, or third country nationals. These operations are of short duration and consist of rapidly inserting a force, occupying an objective, and withdrawing as planned. The amount of force used is normally limited to that required for self-defense and the defense of the operation. The level of hostilities encountered varies with each specific mission. The key factor in planning for this type of operation is the correct appraisal of the politico-military environment in which the operation is to be conducted.

b. Combat health support to NEO is tailored to the size of the military force and the anticipated health needs of the evacuees. Every effort is made to use the existing medical skills of the evacuees.

c. The CHS planner must be included in the mission planning as medical considerations and factors may influence the success of the mission. For example, seriously ill or injured evacuees may not be transportable until medically stabilized. Combat health support planning factors include—

- Assessment of the medical threat.
- Anticipated duration of the operation.
- Size of the force.
- Anticipated number of evacuees.
- Anticipated level of hostilities to be encountered.
- Medical requirements for both the force and the evacuees (including the location for hospitalization, stress control support, medical equipment and supplies, and the rapid medical evacuation of those seriously injured or ill).
- Potential for transferring diseases back to the US.

- Evacuation or disposition of privately owned pets and government-owned animals.
- Potential sources of food supplies and water.
- Security provisions for patients and medical personnel.

3-3. Domestic Support Operations

Traditionally, the US Army has been called upon to assist federal, state, and local governments in times of need. There are four basic categories of domestic support activities (or support to domestic civil authorities) which may be provided. These are disaster assistance, community assistance, environmental assistance, and law enforcement support. (For additional information on domestic support operations, refer to FM 100-19 and the Federal Response Plan [FRP] for Public Law [PL] 93-288, as amended.)

a. Disaster Assistance. The Federal Emergency Management Agency (FEMA) is the federal government's executive agent for implementing federal assistance during disaster relief operations.

(1) Disaster assistance includes those humanitarian and civil defense activities, functions, and missions in which the Army has legal authority to act. The Army provides disaster assistance to states, the District of Columbia, territories, and possessions. Assistance is based upon requests from civil authorities and usually as a result of natural or man-made disasters such as hurricanes, typhoons, earthquakes, or massive explosions. The US Army is the lead agency for urban search and rescue under the provisions of PL 93-288. The Emergency Support Function (ESF) #8 is the Health and Medical Services Annex of the FRP. The purpose of this function is to provide US government assistance to supplement state and local resources in response to public health and medical care needs following a significant natural disaster or man-made event. Assistance provided under ESF #8 is directed by the Department of Health and Human Services (DHHS) through its executive agent, the Assistant Secretary for Health, who heads the US Public Health Service (USPHS). Resources will be furnished when state and local capabilities are overwhelmed and medical and/or public assistance is requested from the federal government. Emergency Support Function #8 will be implemented upon the appropriate state-level request for assistance following the occurrence of a significant natural disaster or man-made event and a determination has been made that a federal response is warranted.

(2) At the onset of the operation, criteria for eligibility of care (such as disaster victims, civilian rescue workers, military retirees and families, and/or other individuals in the disaster area) must be established and disseminated to all supporting units. A determination must also be made as to when this eligibility ends and the patients once again become the responsibility of the local medical infrastructure. Further, a determination must be made of what supplies and services are reimbursable and what governmental agency or organization is responsible for this reimbursement.

(3) Once tasked to provide the support, an assessment of the operational area is required. This is used to determine the correct mix of CHS resources to be employed and the level of support required. (Depending upon the specific situation, this could entail small selected specialty teams or complete organizations such as a CSH.) For command, control, and coordination, it is important for the

military headquarters to be established in a location that will facilitate coordination/liaison. Ideally, the military headquarters can be collocated with the civilian agency in charge of the disaster relief operations.

- The CHS planner must include in his assessment the—

  - Endemic diseases prevalent in the AO (even those considered to be at a low epidemiological level).

  - State of the public works and services (sanitation [including sewer systems], water sources, and garbage pickup).

  - Availability of local medical facilities, personnel, and resources and services being provided by other non-DOD and nongovernment agencies.

  - Numbers of anticipated patients and types and categories of injuries and diseases expected. Consideration must also be given to the type of equipment available in field medical equipment sets (MESs) and what types of equipment will be required to augment these sets. Disaster victims will range in age from newborns to the very old; the type of equipment required for pediatric and geriatric patients is not contained in the standard MES.

  - Anticipated length of the operation.

- The US Army CHS provided in disaster assistance operations may include—

  - Traditional CHS to the employed US Army forces.

  - Management of mass casualty situations (to include triage, treatment, and evacuation) (Appendix J).

  - Delivery of direct medical, nursing, and other health care and services to victims of the disaster.

  - Medical evacuation support out of the immediate disaster area to supporting area hospitals.

  - Preventive medicine support to temporary camps to reduce rodent and arthropod breeding grounds; establish sanitation facilities; provide training (education) in field sanitation, personal hygiene, and PMM; and inspect water supplies (to include ice).

  - Veterinary support for livestock, pets, and/or wild animals that are injured or dislocated and for the inspection of food stuffs for wholesomeness and quality.

  - Combat health logistics support to replenish exhausted medical supplies and equipment and management, storage, and distribution of donated medical supplies and equipment.

- Mental health support to victims and caregivers.
- Dental support on an emergency basis and for maxillofacial injuries.
- Occupational therapy (OT) and physical therapy (PT) to provide preventive and restorative care support.
- Nutrition care and dietetics counseling and education.

- The CHS requirements can be met in a number of different ways depending upon the specific situation, such as—
  - Military medical personnel may be used to assist in staffing local facilities.
  - A military field hospital (such as a CSH) could be deployed to the disaster area.
  - Medical evacuation assets could be used to move patients from the immediate disaster area to a MEDDAC or MEDCEN, or a civilian hospital in the surrounding area for further care.
  - The National Disaster Medical System (NDMS) could be activated. (The NDMS is a nationwide medical mutual aid network between federal and non-federal sectors that includes medical response, patient evacuation, and definitive medical care.)

(4) A communications capability between military participants and civilian agencies must be established. Ambulances must have a long-range communications capability compatible with their civilian counterparts in order to coordinate with hospitals and rescue/emergency vehicles. Units deploying for operations in disaster areas should have all authorized communications equipment on hand. If equipment is not compatible with the civilian counterparts, arrangements must be made to establish a liaison/messenger system or additional equipment must be borrowed or procured.

(5) Refer to Appendix K for additional information on disaster assistance operations.

b. Community Assistance. Community assistance operations are the most frequently conducted domestic support operations. These operations use Army resources to support civilian organizations which promote the general welfare of the community. These missions and operations include public works, education, and training. Additionally, mutual support agreements concerning medical, police, or emergency services may be established with local communities in compliance with existing regulations and directives. The AMEDD has provided assistance to local communities such as—

- Rescue and evacuation through the Military Assistance to Safety and Traffic (MAST) Program. This program uses US Army air ambulances to evacuate severely injured civilians from the place of the incident (automobile accident or job site injury) to an appropriate hospital.
- Rescue of stranded civilians in times of floods, wild fires, or other life-threatening disasters.

- Use of a MEDDAC or MEDCEN as a trauma center for serious injuries when the capability does not exist in the adjacent civilian community, or if the military hospital is closest to the accident (once stabilized, patients are further evacuated to a civilian hospital).

- Use of the US Army Institute of Surgical Research Burn Center for severely burned civilians when other burn care facilities are not available.

- Participation in community health care programs such as health screening and educational presentations.

- Provision of immunization and medical screening clinics (in conjunction with state and local agencies) in rural areas where civilian medical assets are limited.

c. Environmental Assistance. Environmental assistance operations aid civil authorities in preserving, protecting, and enhancing the environment. The US Army strategy rests on the four pillars of compliance, restoration, prevention, and conservation. Compliance includes responding to small-scale hazardous material spills and regulatory support to other government agencies. Restoration involves cleaning up contamination from past operations. Prevention is developing and sharing new technologies that reduce pollution generation. Conservation focuses on the preservation of natural and cultural resources such as wetlands preservation and fighting wildland fires. Army support in these areas may be initiated under disaster assistance or may be executed under separate authority. In the face of a substantial environmental threat, military medical expertise from the US Army Center for Health Promotion and Preventive Medicine (USACHPPM) may be employed. On a smaller scale, a civilian community experiencing a small toxic spill may request PVNTMED support from a neighboring installation to assist in the assessment process.

d. Law Enforcement Support. Operations in support of law enforcement include assistance in counterdrug operations, assistance for civil disturbances, special security operations, combatting terrorism, explosive ordnance disposal, or similar activities. Constitutional and statutory restrictions and corresponding directives and regulations limit the type of support provided. Combat health support will be limited in law enforcement support activities and will normally follow the traditional role of CHS for deployed forces and veterinary support for government-owned animals used in these operations.

3-4. Foreign Humanitarian Assistance

Foreign humanitarian assistance programs relieve or reduce the results of natural or man-made disasters or other conditions such as human pain, disease, hunger, or deprivation that present a serious threat to life or result in great property damage or loss. Humanitarian assistance provided by US forces is limited in scope and duration. It is designed to supplement or complement the efforts of HN civil authorities or agencies that may have primary responsibility for providing humanitarian assistance. Most foreign humanitarian assistance is conducted as joint or multinational operations. The most common operations are disaster relief and refugee programs. (Refer to Appendix L for information on the provisions of Title 10, US Code.)

a. Disaster Relief.

(1) Disaster relief operations provide emergency assistance to victims of natural or man-made disasters abroad. These operations are responses to requests for immediate help and rehabilitation from foreign governments or international agencies. They may include—

- Refugee assistance.
- Food programs.
- Medical treatment and care.
- Other civilian welfare programs.

(2) Combat health support assistance requires a rapid assessment of the health needs produced by the disaster and the rapid tailoring of a medical element to deal with the disaster or deployment of SRTs, if required.

- Preventive medicine plays a key role in the relief effort as natural disasters can disrupt the ecological balance, causing potential outbreaks of disease. Measures to ensure needed sanitation and pest management must be planned for and implemented as soon as possible after the occurrence. Organization of educational efforts and other public health measures to help victims resist potential disease outbreaks are important aspects of PVNTMED support.
- Medical treatment and other health care will most likely have to be provided in rudimentary facilities.
- The CHS element must be able to quickly reach the disaster site with the right mix of medical specialties.
- The CHS element should have the capability to interact with victims in their own language.
- Stress control measures should be applied during and after the operation. (In some instances, stress control measures can be introduced to caregivers prior to their deployment to the disaster site.) These measures are used to maintain effective performance and minimize post-traumatic stress disorder among caregivers, as well as victims.

b. Refugee Operations. Refugee operations may entail the rescue of individuals fleeing a nation and the establishment of temporary safe havens to house and care for these people. Combat health support resources may be required to ensure that—

- Sufficient sanitation facilities are provided.
- Disease surveillance is conducted and disease vectors are controlled.
- Water sources used in the camps are inspected and water is treated, if required, to ensure potability.

- Food wholesomeness standards are maintained.
- Primary health care needs of the refugees are met.

3-5. Security Assistance

a. Through security assistance programs, the US provides defense materiel, military training, and defense-related services by grant, loan, credit, or cash sales to further its national policies and objectives. The Security Assistance Training Program has two primary subcomponents:

- International Military Education and Training Program.
- Foreign Military Sales Program.

b. Military CHS resources may not be used in all types of missions; however, they can be employed to improve health-related quality of life issues. They are also successful in providing effective training for the participating US Army personnel. This support is given by such means as—

- Providing training and support in PMM.
- Developing military training packages to enhance skills of medical paraprofessionals.
- Participating in the Department of State (DOS) cultural exchange program by exchanging US and foreign military medical personnel for visits, training, and education.
- Providing CSC training.

c. The foreign internal defense (FID) augmentation force is a conceptual, composite organization which augments the Security Assistance Organization (SAO). When constituted, the FID augmentation force operates under a US unified command or subordinate joint task force (JTF). Its FID mission is to assist SAOs with training and operational advice, and to provide assistance to HN forces. It employs mobile training teams (MTTs) and small detachments to fulfill specific mission requests. Ideally, this force should be specially trained, area-oriented, mostly language qualified, and available for immediate deployment. Combat health support augmentation to the FID augmentation force can be provided to some extent in all of the CHS functional areas. Particularly effective in this arena are medical treatment, nursing, PVNTMED, stress control, dental, and veterinary resources.

3-6. Nation Assistance

a. Determining the Heath Service Needs of a Host Nation.

(1) In consonance with and under the direction and guidance of the US ambassador, country team, and applicable laws, the command surgeon takes a proactive role in helping to determine the health

service needs of the various countries within his area of responsibility (AOR). Among the many sources of information are the—

- Host nation.
- Armed Forces Medical Intelligence Center.
- Department of State.
- Defense Attaché.
- United States Army CA units.
- United States Agency for International Development (USAID).
- World Health Organization (WHO).
- Nongovernmental organizations.
- Private volunteer organizations.
- Religious organizations.

(2) Regardless of how the requirement is initially determined, the command surgeon must be brought into the planning process at the earliest possible time. This ensures that the necessary military CHS resources are allocated to accomplish the mission.

(3) As one of the goals of using military CHS resources is to enhance the effectiveness of the HN government in the medical arena, the parameters used to assess the HN health service needs will vary with each country. Assessment factors include, but are not limited to—

- State of the general health of the population (to include nutrition).
- State of MH, psychiatric, and social support services.
- State of dental health and dental care services.
- Sanitation and personal hygiene.
- Impact of endemic diseases.
- Status of farm animal health and veterinary services available.
- Primary care capabilities, to include rural areas.
- Morbidity and mortality rates.

- Developmental stage of the HN health care delivery system.
  - Adequacy of secondary and tertiary hospital facilities.
  - Accessibility of the health care delivery system.
  - Education and training levels of health care professionals and technicians.
  - Adequacy of public health department resources.
- Availability and production capability for prosthetic and orthotic devices.
- Existence of health education and health promotion programs targeted at the general population.
- Veterinary medical capabilities in government, industry, and private sectors.
- Status of health care resources.
- Education level of the general population.

(4) An assessment checklist is provided in Appendix E and a medical mission reconnaissance checklist is provided in Appendix M.

b. Health Care Program Development.

(1) In many Third World countries, medical specialties exist, although in limited numbers. Consultation programs involving specialists to share knowledge and new techniques can be quite effective. These programs enhance the HN medical personnel's skills and provide a method of interfacing with their peers on the latest developments in their field of expertise. This is especially helpful in countries which do not have established graduate medical education programs.

(2) In order to develop viable and effective health care programs, a long-term commitment of assistance is required; the *quick fix* is not a solution for ensuring that adequate health care services will remain available to the HN civilian and military populations. Further, the *quick fix* solution may not further US national goals for enhancing the stability of the HN government.

(3) Combat health support operations conducted to enhance the stability of the HN government must be well coordinated with all concerned agencies, such as the—

- Host nation itself and its medical organizations and assets.
- Ambassador and the country team.
- Security Assistance Organization.

- United States Agency for International Development.
- Foreign internal defense augmentation force.
- Civil affairs elements.
- Special operations forces (SOF) (Appendix N).
- World Health Organization.
- Private organizations and religious efforts.

(4) Particular attention should be given to the existence of legal authority for providing training to HN personnel and to the need, in most cases, for reimbursement of the value of training or other services provided.

(5) It should be emphasized that the medical infrastructure which evolves through assistance from US forces must pervade throughout the country and be broad based. It cannot only be concerned with urbanized areas, but must make primary health care available to rural areas also. This often requires convincing the HN government that the expense of hiring and training additional medical and public health personnel for providing rural area services will be justified by the amount of support for the government it quickly generates. For example, the HN health care delivery system can increase access to primary care despite limited resources and a dispersed population. One method is to use nurse practitioners to provide primary care in rural areas. These practitioners could also provide training to local basic- and middle-level health care providers.

(6) The health care programs are tailored to meet the needs of the HN. They should target the basic health necessities initially, with emphasis on health education and on other preventive measures. As the programs evolve, they must become institutionalized to ensure their continued success when US military assistance is withdrawn.

(7) If possible, interregional cooperation between neighboring countries and programs should be fostered. This assists in strengthening relationships between countries and also optimizes the use of scarce resources in the training and development arenas.

(8) Resources in most instances will fall short of need. There will rarely, if ever, be sufficient US personnel, equipment, or supplies to provide care to the entire country, or even for the entire spectrum of disorders within a small area of the country. It must also be understood that the care of chronic disorders and of uncorrectable conditions are beyond the scope of these programs. To provide continuity, these health care programs (carefully coordinated with the HN) require a well-publicized focus to a given area and a schedule to provide return visits.

c. Additional Information. Information on Title 10, US Code is contained in Appendix L.

3-7. Support to Counterdrug Operations

Combat health support to counterdrug operations is limited in nature.

a. The veterinary service provides care and treatment of MWDs used in these operations. Further, the veterinary support may become involved in developing animal husbandry programs which can, in turn, lead to the economic growth of the HN and reduce its dependence on income generated by drug-related agriculture.

b. United States Army medical evacuation resources may also be used to evacuate injured, ill, or wounded soldiers involved in these operations.

3-8. Combatting Terrorism

a. *General*.

(1) Terrorism has become a reality in the modern world. Terrorism can occur throughout the operational continuum. It is defined as the unlawful use or threatened use of force or violence against people or property to coerce or intimidate governments or societies, often to achieve political, religious, or ideological objectives. Combatting terrorism consists of those actions (including antiterrorism and counterterrorism) taken to oppose terrorism.

(2) The tactics used by terrorists include bombings, hijackings, assassinations, and kidnappings. The immediate objectives of terrorism are recognition, coercion, intimidation, and provocation. Terrorism is a tactic that is used across the operational continuum.

(3) Further information on combatting terrorism is contained in Joint Publication (Joint Pub) 3-07.2 and FM 100-20.

b. *Antiterrorism*. Antiterrorism consists of those defensive measures used to reduce the vulnerability of personnel, family members, facilities, and equipment to terrorist acts. This includes the collection and analysis of information to accurately assess the magnitude of the threat. (For the collection of medical information, refer to paragraph 1-5, Appendix A, and FM 8-10-8.)

c. *Counterterrorism*. Counterterrorism is comprised of those offensive measures taken to prevent, deter, and respond to terrorism. Combat health support elements are not directly involved in the counterterrorism aspects of an operation. However, these CHS elements provide traditional CHS to US and friendly forces engaged in these operations.

d. *Combat Health Support Planning Considerations*.

(1) The CHS commander must plan for and conduct active programs which reduce his unit's vulnerability to terrorist actions. A balance must be reached that maintains an appropriate level of vigilance, security, and confidence. This balance should not adversely impact on the mission and result in undue suspicion and stress.

(2) The CHS planner must be aware of the terrorist threat in the planned AO. He must incorporate appropriate safeguards and considerations into the CHS OPLAN. These considerations include—

- Medical.
  - Threat capability for the use of NBC weapons/agents and DE weapons/devices.
  - Provisions for laboratory support to identify suspect agents.
  - Special immunization or chemoprophylaxis for potential BW agents.
  - Command information stressing individual protective measures to include personal hygiene and sanitation.
  - Provisions for safeguarding and inspecting food and water supplies.
  - Provisions for the treatment of contaminated water sources.
  - Stress control resources for debriefing victims, rescuers, and caregivers after a terrorist attack.
  - Provisions for suspect BW and CW agent therapeutics.
  - Medical evacuation under hostile fire or in adverse terrain (FM 8-10-6).
  - Mass casualty situations (Appendix J and FM 8-10-1).
  - Augmentation or reinforcement of medical personnel, supplies, and equipment.
  - Hospitalization (location and requirements).
  - Plans for continued care in the event the MTF is the target of a terrorist attack.
  - Dispersion of units.
  - Care of government-owned animals used in combatting terrorism operations.
  - Specialty response teams (Appendix I).
- Nonmedical.
  - Terrorist threat.
  - Potential targets.

- Terrorist bomb awareness and countermeasures.
- Operations security.
- Procurement of special security equipment, such as portable barriers and intrusion devices.
- Protection of storage and distribution areas.
- Security before, during, and after deployment to the AO.
- Limitations of access to MTFs by reducing the number of entry and exit points.
- Personnel screening of those seeking access to the facility.

e. Preparation and Training.

(1) Although not all terrorist activities result in mass casualty situations, medical elements must plan for and be prepared to respond to mass casualty situations should they occur. All plans must be practiced by those who will participate when the plans are implemented. Both planning and practice must be flexible enough to account for the disruption and reduced capability which may result from a terrorist act. By using practice situations, the CHS commander ensures that the required internal and external coordination has been effected. The practice also ensures that the unit or MTF personnel are familiar with their duties and assignments during an actual situation. At a minimum, the mass casualty plan should be exercised at least twice yearly, and more often in highly vulnerable locations. Contingency plans must also be prepared to conduct the CHS mission, even if the MTF is the terrorist target.

(2) All newly assigned personnel should be provided with an orientation that addresses the terrorist threat. The discussion can include the newly assigned personnel's role in combatting terrorism and in mass casualty situations. It can include information on what to do if the MTF is the target of terrorists.

(3) Unit training should be conducted on topics such as—

- Security.
- Terrorist bomb awareness and countermeasures.
- How to talk to terrorists or hostage takers until relieved by law enforcement experts.
- Dealing with bystanders to terrorist incidents.
- Psychological debriefing and medical management of hostages upon rescue or release.
- Force survivability.

- Nuclear, biological, and chemical defense.
- Other pertinent topics.

(4) To more effectively use medical personnel, nonpatient care personnel assigned to the unit should be instructed in support duties, such as driving, ensuring the security of the unit area, carrying litters (FM 8-10-6), acting as messengers, and providing first aid in the MINIMAL care area, as required.

3-9. Peace Support Operations

Peace support operations encompass a wide range of activities which establish or sustain peaceful conditions or foster the conditions essential to establishing peace. Peace support operations include essentially diplomatic activities to support diplomacy in peacekeeping and peace enforcement. Other activities which support peace operations may include humanitarian assistance (paragraph 3-4) and nation assistance (paragraph 3-6).

a. Peacekeeping Operations. Traditional peacekeeping operations include such activities as monitoring and supervising truces to facilitate diplomatic efforts to reach a political settlement of the dispute. The AMEDD role in peacekeeping operations is to provide CHS to the peacekeeping force. This force may consist of elements from the other Services or may be a multinational force. It may also include US government civilian employees, civilian contractors, and UN officials.

(1) A theater medical evacuation policy is established based on the capabilities of the in-country medical resources. The evacuation policy normally permits only limited treatment and holding capability in-country with evacuation from the AO for definitive care.

(2) Due to the inherent neutrality of a peacekeeping force, it is important for CHS units and personnel to adhere to the parameters of their stated mission. Only those missions involving HN personnel or facilities which are authorized by the command authority should be accomplished. Independent, unplanned medical humanitarian assistance programs are not to be undertaken by the CHS element of the peacekeeping force.

(3) The CHS package for a peacekeeping force is often limited in size; therefore, it must be carefully tailored to satisfy mission-unique requirements. Preventive medicine measures must be employed and receive command emphasis to minimize the medical threat. The DNBI rate is more significant in these operations than are combat wounds. Operational factors in peacekeeping operations may cause stress disorders. These disorders include misconduct stress behaviors which may threaten the success of the peacekeeping mission. Mental health and CSC personnel can help prevent or manage these complications.

(*a*) The CHS package for a peacekeeping operation must be specifically tailored to meet the needs of and be compatible with the size of the supported force. If a brigade or division force is deployed, sufficient organic medical resources should be included in the force composition. Further, augmentation from corps assets (corps support slice) may be required.

(*b*) For successful CHS operations, the CHS planner must ensure that—

- Preventive medicine support is sufficient to identify the medical threat and to provide pest management.
- The size of the CHS element is sufficient to provide adequate care.
- Combat health logistics links for resupply of Class VIII supplies are well defined.
- Medical evacuation platforms and routes are planned for and coordinated with the other Services, allied nations, or coalition forces.
- Veterinary support is sufficient for subsistence procurement and surveillance of foodstuffs and care of government-owned animals.
- A mass casualty plan is prepared and provision for the practice of the plan is made.
- Alternate sources of CHS are considered, and if appropriate, incorporated into the plan. These alternate sources may include, but are not limited to—
  - Diplomatic flights for medical evacuation or resupply.
  - Embassy and HN physicians, if available.
  - Allied nations and coalition forces capabilities for emergency care and hospitalization.
- Contingency plans are prepared for CHS in the event of the withdrawal of the peacekeeping force or the escalation of hostilities. If hospitalization support is not available within the AO, plans must be coordinated with those units providing hospitalization support. In light of the potential terrorist threat in peacekeeping operations, it is imperative that hospitalization support (location, services available, blood supply, and capacity) be available in the event of a mass casualty situation.
- Combat health support elements employ passive defense measures to reduce their vulnerability against sabotage or terrorist incidents. These measures include such actions as light and noise discipline or restricting access into an area by channeling the flow of traffic within the area.

(4) For additional information on peacekeeping operations, refer to Joint Pub 3-07.2, FM 100-20, and FM 100-23.

b. Peace Enforcement Operations. Peace enforcement operations are a form of combat, armed intervention, or the physical threat of armed intervention. They are used to compel compliance with international sanctions or resolutions and include combat operations to establish or reestablish conditions conducive to peace, such as forcible separation of belligerents.

(1) Peace enforcement operations are military intervention operations in support of diplomatic efforts to restore peace. They also establish the conditions favorable for the insertion of a peacekeeping force between hostile factions that may not be consenting to the intervention. Although the intent of peace enforcement is to settle a political problem without resorting to violence, coercion is applied when necessary. Violence can easily escalate and CHS plans must provide for the possibility of supporting the force in moderate to heavy combat.

(2) Combat health support elements are tailored to the—

- Size of the peace enforcement contingent.
- Level of hostilities to be encountered.
- Anticipated duration of the mission.

(3) The requirements for CHS in this type of operation are to provide medical care in an austere environment with medical evacuation out of the AO for more definitive care. The CHS planner should be included in the mission planning process to ensure that adequate CHS resources are provided. The CHS planner should consider, but not be limited to, the following:

- Commander's intent and concept of operations.
- Medical threat.
- Anticipated patient work load.
- Anticipated areas of patient density.
- Sanitation and disruption of garbage disposal, water, and sewer services.
- Anticipated civilian casualties requiring medical care, if it is a mission requirement.
- Anticipated EPW medical care requirements.
- Lengthening LOC.
- Medical evacuation (including patient collecting points, ambulance exchange points (AXPs), and the ambulance shuttle system).
- Location of hospitalization assets or services.
- Coordination with the other Services, allies, coalition partners, and HN.
- Operations conducted on urbanized terrain.

- Combat health logistics requirements and procedures.

3-10. Show of Force

a. A show of force lends credibility to a nation's promises and commitments; increases its regional influence; and demonstrates its resolve to use military force as an instrument of national power. Further, the National Command Authorities (NCA) order these operations to bolster and reassure friends and allies.

b. Combat health support for show of force follows the traditional role of providing CHS to a combat force.

(1) The size of the combat force, the mission, the duration of the operation, the assessment of the medical threat, the evacuation policy, and the anticipated level of hostilities to be encountered determine—

- Range of services to be provided.
- Size of the medical contingent.
- Anticipated patient load.
- Requirements for Class VIII supply and resupply.

(2) The CHS planner must be included early on in the planning process for the mission. This is to ensure that adequate CHS resources are planned for and committed to support the show of force and are capable of transitioning to a combat role, if required. Further, if it is a joint or combined operation, the CHS package must be thoroughly coordinated with all parties involved to prevent a duplication of or a gap in the CHS coverage.

3-11. Support for Insurgencies and Counterinsurgencies

The arenas of support for insurgency and counterinsurgency provide the greatest challenges and are the most complex programs in stability and support operations. In these areas, the possibility exists that the traditional roles and methods of employment of US military forces may be reversed (CSS or CS elements entering the theater prior to the combat units). The uniqueness of these settings requires thoroughly coordinated planning and flexibility on the part of the commander to successfully accomplish his mission. Agencies of the federal government (other than DOD) normally exercise overall direction of efforts in support for insurgency and counterinsurgency. The US military actions serve a supporting role. Once legally tasked by the NCA for commitment to support or defeat an insurgency, US military forces assist either HN governments or insurgent movements. For the legal considerations concerning insurgency and counterinsurgency operations, refer to FM 100-20.

a. Insurgency. Insurgency is an organized, armed political struggle whose goal may be the seizure of power through revolutionary takeover and replacement of the existing government. In some cases, however, insurgency is undertaken to break away from government control and establish an autonomous state within traditional ethnic or religious territorial bounds. It may even be conducted to extract limited political concessions that are unattainable through less violent means.

(1) Insurgencies succeed by mobilizing human and material resources to provide both active and passive support. Mobilization produces skilled workers and fighters, raises money, and acquires weapons, equipment, and supplies of all kinds. Mobilization grows out of intense popular dissatisfaction with existing political and social conditions. Active supporters consider conditions intolerable. They are willing to risk death in violent confrontations with their government to effect change. The insurgent leadership articulates their dissatisfaction, placing the blame on the government and offering a program to improve conditions. The insurgent leadership then provides organizational and managerial skills to transform disaffected people into an effective force for political action. Ultimately, the insurgents need the active support of a majority of the politically active people and the passive support of the greater part of the population.

(2) This dynamic process may take place within any political system, including a democracy. Insurgency arises when the government is unable or unwilling to redress the demands of important social groups and when its opponents use violence to change the government's position. Insurgencies are coalitions of disparate forces united by their common opposition toward the government. To the extent that these coalitions find common ground, their prospects improve. Their differences are compromised, negotiated, and influenced as groups evolve. To be successful, an insurgency must develop unifying leadership, doctrine, organization, and a vision of the future. Only the seeds of these elements are present when an insurgency begins; the insurgents must continually review and revise them.

(3) The CHS requirements for support of an insurgency are determined by the—

- Needs of the insurgent movement.
- Political, social, and economic issues involved.
- Resources available.
- Existence of clear, legal authority.

(4) Combat health support operations may entail advice and—

- Training in PMM and sanitation. Information on PVNTMED and sanitation topics is contained in—
  - Field Manuals 8-10-7, 8-33, 8-250, 21-10, and 21-10-1 and Technical Manual (TM) 5-632.
  - Technical Bulletin, Medical-series.

- Armed Forces Medical Intelligence Center products. (Refer to FM 8-10-8 for additional information on AFMIC products.)
- World Health Organization reports and publications.
- Pan American Health Organization reports and publications.

- Assisting in the establishment of a viable medical infrastructure to attend to the medical needs of the insurgents. The CHS organization supporting the insurgents is normally minimally staffed. It must provide on a limited basis all facets of the health care spectrum from EMT at the point of injury through hospitalization and convalescent care. Army Nurse Corps officers may serve as trainers emphasizing those skills necessary for EMT; triage; mass casualty management; and nursing aspects of pre- and postoperative management. These nurses may also provide first-aid training to the insurgent personnel. One of the key factors in maintaining high morale among soldiers is the knowledge that if wounded, medical care will be available. Depending on the tactical situation, terrain, and other environmental conditions, treatment stations may be housed in caves, tunnels, existing buildings, or temporary shelters. Due to the fluidity of stability and support operations, the treatment station established should be no larger than that necessary to accomplish the mission. It should be 100 percent mobile.

- Assisting in planning health care programs. These programs may be for the populace once the insurgents have attained the position to implement them. Development of CHS programs must be based on the real or perceived needs of the populace. A balance between short- and long-term programs must be attained. Short-term programs (such as extraction of teeth) provide visibility and immediate recognition. Long-term programs, however, are the best means to resolve the population's dissatisfaction with the health care delivery system. They are also effective in improving the standard of living and quality of life. Long-term programs include such projects as—
  - Veterinary care and animal husbandry.
  - Building of sanitation facilities.
  - Training of medical personnel.
  - Providing nutrition and rehabilitation guidance.
  - Providing dental public health programs.
  - Providing health education.

(5) Unconventional warfare (UW) is a broad spectrum of military and paramilitary operations. It is a tactic which insurgent forces may choose to use. These operations are normally of long duration and are predominantly conducted by indigenous or surrogate forces. These forces are organized, trained, equipped, supported, and directed in varying degrees by an external source. Unconventional warfare includes guerrilla warfare and other direct offensive, low-visibility, covert, or clandestine operations. It also includes the indirect activities of subversion, sabotage, intelligence collection, evasion,

and escape. The primary forces used in UW are SOF. (For additional information concerning SOF, refer to Appendix N.)

- The goals of CHS operations in support of UW are to conserve the guerrilla forces' fighting strength and to assist in securing local population support for US and insurgent forces operating within joint special operations areas (JSOAs).

- Combat health support elements supporting the insurgent forces must be mobile, responsive, and effective in preventing disease and returning the sick and wounded to duty. There is no safe rear area where the guerrilla takes his casualties for treatment. Wounded and ill personnel become a tactical rather than a logistical problem.

- In a UW situation, indigenous medical personnel may provide assistance during combat operations by establishing casualty collecting points. This permits the remaining members of the insurgent force to continue fighting. Casualties at collecting points are later evacuated to the guerrilla base or to a guerrilla medical facility. As the operation develops, evacuation of the more seriously wounded, injured, or diseased personnel to friendly areas is accomplished by establishing clandestine evacuation nets if security does not permit using aeromedical evacuation.

- Combat health support requirements within the JSOA differ from those posed by conventional forces. In UW, battle casualties are normally fewer and the incidence of disease and malnutrition is often higher.

- Overlaying conventional military CHS assets on UW operations can only be accomplished if it does not compromise the security of the mission.

b. Counterinsurgency.

(1) *Internal defense and development strategy.* The internal defense and development (IDAD) strategy is the full range of measures taken by a nation to promote its growth and protect itself from subversion, lawlessness, and insurgency. It focuses on building viable institutions (political, economic, military, and social) that respond to the needs of the society. Developmental programs carefully planned, implemented, and publicized can serve the interests of population groups and deny exploitable health issues to the insurgents.

- The fundamental thrust of the IDAD strategy is toward preventing the escalation of internal conflict. Should insurgency occur, emphasis is placed on holding down the level of violence. The population must be mobilized to participate in IDAD efforts. Thus, IDAD is an overall strategy for the prevention of insurgency; or if an insurgency should develop, for counterinsurgency activities. Prevention is accomplished through—

  - Forestalling and defeating the threat posed by insurgent organizations.

  - Working to correct conditions that enhance their chances of success.

- Quality of life issues, such as the availability of health care, can be prominent issues that motivate insurgents to demand change. A thoroughly planned and coordinated IDAD strategy (which implements the needed health care reforms and focuses on other quality of life issues) can motivate the population to support the HN government rather than the insurgent group. These programs can enhance the legitimacy of the HN government while undermining the legitimacy of the insurgent group.

(2) *Goals and objectives of military combat health support in foreign internal defense.*

- Foreign internal defense is the US role in the IDAD strategy. It is the participation by civilian and military agencies of a government in any of the action programs taken by another government to free and protect its society from subversion, lawlessness, and insurgency.

- The goals and objectives of military CHS in this environment are defined in the commander's regional strategy. Each HN has circumstances which differ from its neighbors' and are unique to its own situation. These characteristics include social, economic, cultural, military, and political realities within the HN. The CHS planner needs to develop specific goals and objectives for each country within the region.

- In developing these goals and objectives, the CHS planner ensures that the—

  - Plan is developed with the HN's assistance.

  - Plan enhances rather than replaces the HN's existing programs.

- Host nation has the resources to continue the programs if the US military effort is sharply curtailed or discontinued.

- Host nation receives the credit for the program rather than the US military. This is accomplished by ensuring that all CHS operations include representatives of the HN or its military.

(3) *The role of military combat health support in foreign internal defense.*

- As with the goals and objectives, the actual role of military CHS is defined in the commander's regional strategy. It is important that any CHS operations conducted in stability and support operations are thoroughly planned, coordinated, and included in this strategy.

- The specific role of CHS in FID varies depending upon the stage of development and the political, economic, military, and social situations of the country where employed. However, some general roles are to—

  - Assist the HN in identifying the health needs of the population.

  - Work in concert with the HN in developing programs aimed at the resolution of potential or actual health problems.

- Provide guidance for the development of the HN's medical infrastructure.
- Develop, in concert with the HN, training standards to be used by the HN.
- Develop and document the minimum and basic medical supplies and equipment levels for the conduct of HN operations and programs.
- Assist the HN's health planners in prioritizing health care needs which are competing for scarce resources.
- Train HN personnel to administer and maintain programs without outside assistance.
- Regardless of the specific medical missions, the US military role should be unobtrusive. The HN government must be seen as leading the effort to improve the quality of life for the populace, thus making the desired positive impression. Concern for the health of the people must be viewed as a central precept of the HN government, not as a program driven by outside American influences. To facilitate this end, press coverage of counterinsurgency, humanitarian assistance, or nation assistance operations should focus (photographs and stories) on the actions of the HN participants and not on US involvement. Where possible, the US role should be more advisory, consultative, or training in nature, enhancing the HN practitioners skills, thereby enabling him to provide the direct patient care to his nation's citizenry.
- The role of military CHS in a foreign country is determined by the US ambassador (except when the US military forces are under the command of the combatant commander), who is responsible for and has authority over all US government activities within the country. Actions by CHS personnel/units will be fully integrated with the general plan of the US country team. The emerging role of CHS in counterinsurgency operations involves a long-term commitment in consonance with US national policy and goals and the socioeconomic environment of the HN. As stated in paragraph 3-6*b*, the *quick fix* should be avoided, as it only raises the expectations of the populace. When US assistance is withdrawn, the *quick fix* solution may leave the HN government without the capability to sustain the same level of care. This situation results in increasing the population's dissatisfaction with their government.

(4) *Combat health support needs of the host nation military.* An assessment of the HN's military medical infrastructure and capabilities (similar to the civilian sector) should be completed. The morale of the fighting soldier is often dependent upon the knowledge that he will receive adequate and timely medical attention when wounded or ill. If the HN's military medical infrastructure does not have the capability to provide this type of responsive medical care, the effectiveness of the fighting force may suffer. Assessment factors include—

- Status of field sanitation and personal hygiene practices.
- Status of an immunization program for the armed forces.
- Level of training combat medics receive for providing initial medical care.

- Status of a medical evacuation system.
- Existence of field medical units (including command and control [C2] elements).
- Status of unit and individual training in first aid (self-aid, buddy aid, and combat lifesaver skills) in the armed forces.
- Stage of development of the medical organization, including the professional development of medical and paraprofessional personnel.
- Stage of development of (or improvement of) a military hospitalization system.
- Status of the CHL system (including the development of standardized MESs for field operations).
- Status of CSC prevention programs and management of stress cases.
- Status of dental services.
- Existence of medical and nursing training programs and standards of training.
- Level of recruitment and training of civilian health care professionals for duty with the military.
- Status of malnutrition among the armed forces.
- Educational level of members of the armed forces.
- Development of rehabilitative services such as OT and PT and treatment protocols of veterinary services.

3-12. Attacks and Raids

The US conducts attacks and raids for specific purposes other than gaining or holding terrain. Attacks and raids can support rescue and recovery operations, or destroy or seize equipment or facilities which demonstrably threaten national and collective security interests. They can also support counterdrug operations by destroying narcotics production or transshipment facilities, or supporting a HN's actions in this regard.

a. Planning.

(1) Conventional CHS planning (FM 8-55) is required to meet the needs of the forces deployed. These operations may be conducted in areas without established military support bases. The only support available may be that which was preplanned and accompanied the force. Combat health

support planning, therefore, must be comprehensive, thoroughly coordinated, and flexible enough to meet unanticipated requirements. Sufficient CHS resources must accompany the lead forces to ensure that—

- Medical care can be provided.
- Preventive medicine measures are instituted by the initially deployed forces.

(2) The mission, enemy, terrain, troops and time available (METT-T) factors and medical threat requirements may dictate that special equipment (such as mosquito netting or mountaineering equipment) be required to accomplish the mission. The CHS planner must ensure that sufficient quantities are available for use by medical personnel and, if need be, by their patients.

(3) In these short-duration operations, characterized by the rapid insertion of a combat force, environmental (heat and cold) injuries may occur if there was insufficient time to acclimatize the force. For example, when moving troops from a cold climate to a tropical area, they may suffer from heat injuries. Planning for sufficient quantities of replacement fluids (water) can minimize this threat.

(4) Combat health support planning should also include the anticipated medical care requirements for EPW, detained or retained personnel, and civilian casualties. It should also consider the effects of the Geneva Conventions (FM 8-10) or other legal considerations on these operations.

(5) The medical evacuation of sick, injured, or wounded soldiers from the AO may require coordination with the other Services. United States Air Force or USN assets may be used to insert the force and may provide the only means of evacuating patients from the AO. Coordination for the backhaul of patients on nonmedical transportation assets, establishment of a mobile aeromedical staging facility (MASF), or the landing of Army air ambulances on USN ships must be effected if the evacuation mission is to be successfully accomplished. Early coordination with joint service elements is essential to accomplish these evacuation tasks.

(6) The CHS planner must also ensure that CSC personnel are available to debrief soldiers who are injured or wounded, or who suffer from BF.

b. Urbanized Terrain. Throughout history, operations have been conducted on urbanized terrain. Some recent examples include Hue, Beirut, and Panama City. Military operations on urbanized terrain (MOUT) are those military actions planned and conducted on a terrain where man-made structures impact on the tactical options available to the commander. This terrain is characterized by a three dimensional battlefield, having considerable rubble, ready-made fortified fighting positions, and an isolating effect on all combat, CS, and CSS elements. Of concern to medical and tactical planners alike, is the need to plan, train, prepare, and equip for this environment. The CHS mission will include the location, treatment, and evacuation of wounded from under, above, and at ground level. Additional information on combat in built-up areas is contained in FM 90-10 and FM 90-10-1.

(1) *Medical threat.* Military operations conducted in built-up areas result in significant differences in both the frequency and types of diseases and wounds experienced.

- Civilian populations may experience increasing disease rates, as well as less common diseases, as a direct result of the environmental conditions imposed by MOUT. Human defenses to all endemic diseases are reduced by—
    - Lack of hygiene.
    - Exposure.
    - Hunger.
    - Anxiety.
- The deliberate introduction of infectious diseases via water, food, aerosols, human carriers, or contaminated material can be expected from some adversaries.
- The razing of structures creates rodent and arthropod shelters. The factors which combine to promote the rapid expansion of rodent and arthropod vector populations and the diseases they transmit include—
    - Interruption of water and sewer systems.
    - Disruption of garbage collection.
    - Disruption of health care services.
    - Presence of carrion.
    - Damage to food storage and preparation facilities.
- Secondary wounding missiles will be common from the abundance of glass, steel, and stone. Building collapses will result in more numerous crush injuries. An increased potential for burns and inhalation injuries will result from—
    - Burning fuels, vehicles, and structures.
    - Smoke produced by these fires.
    - Toxic fumes and smoke generated by obscurants.
    - Fuel-air and other explosive devices.
- Stressors, such as the presence of civilians who may be hostile, increase the risk of misconduct stress behaviors and subsequent post-traumatic stress disorders among US forces.

(2) *Equipment*. In MOUT, it is essential for CHS elements to have the capability for the extraction and evacuation of casualties from above and below ground level. Materiel requirements include—

- Axes, crowbars, and other tools to break through barriers.

- Special harnesses; portable block and tackle equipment; ropes; grappling hooks; collapsible litters; light-weight collapsible ladders; heavy gloves; and casualty blankets with shielding for lowering casualties from buildings or moving them from one building to another at some distance above the ground using pulleys.

- Equipment for the safe and quick retrieval from craters, basements, storm drains, sewers, and subways. Casualties may have to be extracted from beneath rubble and debris.

- Intravenous (IV) fluids and IV starter sets in additional quantities to treat the increase in wounds and trauma injuries which are anticipated. Individual soldiers may carry these fluids to hasten their availability and shorten the time between wounding or injury and the initiation of vascular volume replacement. This also reduces the weight and cube of supplies carried by the medical treatment teams. In situations where troops are suffering from severe heat exhaustion or environmental injuries, the fluid may be taken orally if an IV starter set is not available.

- Air ambulances equipped with a rescue hoist which may be able to evacuate casualties from the roofs of buildings or may be able to insert needed medical personnel and supplies.

- Effective communications that face many obstacles during MOUT. Line of sight radios are not effective and individual soldiers will normally not have access to radio equipment. The use of alternate forms of communications, such as markers, panels, or field expedients (fatigue jackets or T-shirts), which can be displayed by the wounded or injured soldiers indicating where they may be found should be considered.

(3) *Medical evacuation*.

- Medical evacuation in the MOUT environment is a labor-intensive effort. Due to rubble, debris, barricades, and destroyed roadways, much of the evacuation effort must be accomplished by manual carries or litter teams. When this occurs, an ambulance shuttle system or a litter shuttle should be established.

- Casualty collecting points should be established at relatively secure areas accessible to both ground and air ambulances. Collecting points should be designated in advance of the operation and should—

    - Offer cover from enemy fires.

    - Be located as far forward as the tactical situation permits.

    - Be identified by an unmistakable feature (natural or man-made).

- Allow rapid turnaround of ambulances and other ground vehicles.

- Be well separated from fuel and ammunition depots, motor pools, reserve forces, or other lucrative enemy targets, as well as civilian hazards such as gas stations or chemical factories.

- For additional information on medical evacuation in this environment, refer to FM 8-10-6.

(4) *First-aid skills*. Self-aid, buddy aid, and combat lifesaver skills are essential. Due to the isolated nature of this combat environment, injured and wounded soldiers may not be reached by the combat medic for extensive periods of time after the injury or wound has been sustained.

(5) *Civilian casualties and refugees*.

(*a*) In MOUT, civilian casualties occur. To the greatest extent possible, civilian casualties should be treated by local HN medical personnel and facilities. The injuries sustained by the civilian population can be caused by direct action (such as being caught in a cross-fire) or by indirect action (such as the collapse of a structure that was weakened by military action). In either case, humanitarian assistance may be required to perform lifesaving procedures. Once stabilized, these patients are transferred to a HN facility. The CHS planner must, therefore, consider the requirements for—

- Additional logistics support.

- Higher than normal medical supply stockage levels.

- Additional medical equipment.

- Increased staffing of PVNTMED personnel.

- Augmentation or reinforcement of the deployed medical assets.

(*b*) In addition to the casualties mentioned above, the number of refugees may increase rapidly as the operation progresses.

- When large numbers of refugees are experienced, the medical threat to both the civilian and the military populations will become unacceptable. This is due to the potential overcrowding of facilities, the lack of sufficient sanitary facilities, and the increased requirements for potable water and food supplies.

- Coordination with the HN medical infrastructure should be accomplished to provide essential health services to the refugee population.

(*c*) Combat health support planners must ensure that the potential requirements for providing humanitarian assistance and PMM to the civilian community are incorporated into the plan. This

is necessary to ensure that the level of CHS to our forces is not degraded by the civilian casualty or refugee situation. Specific planning considerations include—

- Estimated patient work load and types of injuries.
- Requirements for providing emergency pediatric, obstetrical and gynecological, and geriatric care.
- Duration of the operation and hour of day in which the operation is initiated (such as at midnight when most people are inside their homes or at 0700 when people are leaving for work).
- Population density in the AO.
- Location and availability of Class VIII materiel.
- Availability of sanitation facilities.
- Location of refugee camps or holding areas and anticipated duration of stay in the area.
- Location and availability of potable water.
- Location and availability of local food supplies or Class I.
- Endemic diseases and pest management.
- Veterinary resources for ensuring the wholesomeness of locally procured food supplies and surveillance for use in humanitarian activities.

CHAPTER 4

SPECIFIC FUNCTIONAL AREA CONSIDERATIONS IN STABILITY OPERATIONS AND SUPPORT OPERATIONS

This chapter discusses specific concerns of the various AMEDD functional areas as they pertain to stability and support operations. The area medical support functional area applies across the continuum of stability and support operations and will not be discussed separately. As area medical support concerns providing CHS to units without organic CHS capability, the constrained size of the forces deployed in stability and support operations necessitates that this function be applied throughout stability and support operations planning. For additional information on the AMEDD functional areas, refer to FM 8-10 and FM 8-55.

Section I. COMMAND, CONTROL, COMMUNICATIONS, COMPUTERS, AND INTELLIGENCE

4-1. General

Command, control, communications, computers, and intelligence (C4I) are the key ingredients to managing CHS missions in stability and support operations. Commonality of communications means, a delineated chain of command, and up-to-date medical intelligence will enable the CHS commander to task-organize his resources, develop a plan, execute the mission in the most timely and effective manner, and be able to realign and redeploy his assets as support requirements change.

4-2. Considerations

a. In stability and support operations, it is essential that all participants communicate effectively. Most operations conducted in this environment will be joint or combined in nature and may also involve nonmilitary and nongovernmental organizations and agencies. As the participants are not all from the same organization, interoperability of communications means cannot be assured. If the communications equipment of the various participants is not compatible, then a liaison/messenger system must be established until compatible equipment is either borrowed or procured. In combined operations, the liaison needs to be able to speak the language of the headquarters to which assigned or be able to communicate effectively through an interpreter.

b. In joint operations, the JTF headquarters ensures standardized reporting formats, times, and requirements are established early in the operation. With the proliferation of Service component forms and local formats governed by parent unit standing operating procedures (SOPs), it is unlikely that participating Service units/personnel will report similar types of information at similar times. It is essential, therefore, that the Army service component surgeon be prepared to develop an internal SOP to incorporate newly established routines and emergency actions/procedures. The degree of administrative support required for an operation is dependent upon the type of operation. For example, in disaster assistance operations, the C4I headquarters must ensure that it provides all of its own administrative support (supplies, equipment, shelter, subsistence, and water) as these items and services may not be available in the disaster area.

c. In stability and support operational scenarios, a clear understanding of who is in charge and a spirit of cooperation must be established, as civilian agencies, other federal and HN agencies, or the ambassador may have the primary responsibility for providing and coordinating support.

d. The legal aspect of stability and support operations is an important area for the commander to consider. Depending upon the scenario, there may be designated groups of individuals authorized care who are normally not beneficiaries of the military health care system, such as disaster victims, rescue workers, UN officials, civilian contractors, or HN civilians. The CHS commander must determine who may receive services, how the government is to be reimbursed for these services and materiel, and what is the malpractice liability (to include credentialing and scope of practice of nonmilitary health care professionals).

Section II. PATIENT EVACUATION AND MEDICAL REGULATING

4-3. General

Patient evacuation is the link between the successive echelons of care in the CHS system. It provides the means to transport a patient while providing continuous medical care en route. This capability enhances the prognosis of the patient. Medical regulating provides the means of directing the patient to the MTF best capable of providing the required care.

4-4. Patient Evacuation and Medical Regulating Support to Stability and Support Operations

a. During NEO, those persons who are injured, wounded, or ill are treated and stabilized by the medical element accompanying the NEO force. Once stabilized they are evacuated by the NEO force.

(1) In NEO conducted in a permissive environment (no apparent physical threat to the evacuees), sick, injured, or wounded persons should be evacuated on dedicated medical platforms, if at all possible. In an uncertain or hostile environment, the transportation assets used to insert and extract the NEO force are normally used to evacuate the patients. The medical personnel accompanying the force provide en route medical care until the NEO force reaches an intermediate staging base (ISB) or safe haven. Those evacuees requiring medical care are then transferred to dedicated medical evacuation platforms for further evacuation to MTFs capable of providing the required care.

(2) Medical regulating coordination is accomplished by the medical element accompanying the NEO force (using the organic communications capability of the force) to ensure dedicated medical evacuation platforms are available for transferring patients to when the NEO force reaches the ISB or a safe haven. Additionally, this coordination ensures the availability of specialty care hospital beds in the supporting MTFs. The medical regulating function is accomplished with the medical group, brigade, or command MRO, the TPMRC, or the Global Patient Movement Requirements Center (GPMRC) supporting the operation.

b. Patient evacuation and medical regulating conducted in domestic support operations will differ with the type of activity supported.

(1) Some operations occur on a routine basis and are detailed in support agreements with the local community. For example, the MAST program uses Army air ambulances to evacuate severely injured civilians from the place of the incident (automobile accident or job site) to the appropriate area hospital.

(2) In other operations, patient evacuation capability may be required due to a crisis such as an earthquake or flood. This support may be required at the community level (localized flooding limited to a small geographical location) or at a state or federal level (such as in major earthquakes or hurricanes). The patient evacuation role of US Army air ambulances may also be expanded in these operations to include executing rescues using the rescue hoist (for example, removing people from the roofs of their homes in floods).

(3) The commander must have clearly defined guidelines as to the scope of the operation and, where applicable, the funding mechanism for reimbursing the government for the expenses incurred.

(4) In operations requiring the activation of the NDMS and when the DOD is tasked to provide evacuation support, US Army evacuation assets (air and ground) will normally be used to move patients within the disaster area while USAF fixed-wing assets are used to move patients out of the AO.

(5) The DOD agency responsible for the medical regulating of patients from major disaster sites that require activation of the NDMS is the GPMRC. In many domestic support operations (not requiring activation of the NDMS), military hospitals may not be participants in providing direct patient care, hospitalization capability, or ancillary services, as local civilian medical facilities will have sufficient capability. The command surgeon, in conjunction with the civilian medical community, will be instrumental in devising and implementing a medical regulating plan to regulate the flow of patients to the various civilian facilities.

(6) The FRP provides detailed information on patient evacuation/medical regulating requirements and responsibilities during federal responses.

c. In humanitarian assistance operations, medical evacuation is usually not a significant factor, as the patients are treated wherever the treatment facility is established. In isolated cases, patients might be evacuated to a metropolitan area for more definitive care, but this is not the norm for these operations. However, medical evacuation platforms (especially helicopters) may be used to move the treatment element to the proposed site where the humanitarian assistance operation is to be conducted. This is the more likely support scenario for the use of medical evacuation platforms.

d. In disaster relief operations, medical evacuation support is dependent upon the situation. If the disaster occurs within a heavily populated area, but there is little damage/injury done to the local medical facilities/personnel, then patients may be cared for in existing local facilities. Evacuation to these facilities is by any form of conveyance available (emergency vehicles for the more seriously injured and privately owned or business transportation assets for the less seriously injured). However, if the disaster occurs in a remote area, or if there is substantial damage/injury to local medical facilities and personnel, patients may initially require evacuation out of the disaster site for definitive treatment. Unless a military unit is in proximity of the disaster and is a first responder, the initial evacuation of accessible victims from the immediate disaster area will already be accomplished. However, military evacuation expertise in the

extraction of victims from above and below the ground may be required as rescue operations continue. Patients must be regulated to medical facilities within the disaster area to ensure that one facility does not become overwhelmed while another is sitting idle. This does not, however, mean that a formal medical regulating system is established, such as the DOD uses. If patients are to be evacuated out of the AO by USAF evacuation assets and regulated into US military, Department of Veterans Affairs (DVA), or civilian hospitals, the GPMRC may be activated. The CHS planner must remember that these operations are often headed by other than military personnel and the medical evacuation plan must be sufficiently flexible to support and complement the overall plan for the operation.

e. The factors to consider in planning for patient evacuation in combatting terrorism operations include—

- Using medical and nonmedical transportation assets to evacuate casualties in mass casualty situations. If nonmedical assets are used, planning should include augmenting these assets with medical personnel to provide en route medical care.

- Applying techniques for evacuating patients under hostile fire or on adverse terrain (from rubble or from above or below ground level). (For additional information, refer to FM 8-10-6.)

- Ensuring security measures (such as establishing checkpoints, screening personnel and vehicles, and limiting access to the MTF area) are implemented.

Section III. HOSPITALIZATION AND TREATMENT

4-5. General

The hospitalization and treatment function in support of each stability and support operational scenario will differ. In many stability and support operational missions, the CHS element is constrained in size, necessitating that some services (such as hospitalization) be provided outside of the AO. As the CHS element is normally task-organized for the specific mission, CHS resources that are only deployed with a hospital may be included in the task organization (even though a hospital unit will not be deployed).

4-6. Nonphysician Health Care Practitioners

The AMEDD has a variety of skilled medical professionals who provide direct patient care, rehabilitative services, and consultation to other medical professionals in HNs or in domestic support operations. Many of these medical professionals provide ancillary services within the hospital, but during stability and support operations may also be employed outside of the hospital setting. (Army Regulation 40-48 defines the primary care roles of nonphysician health care practitioners.)

a. Physical and Occupational Therapy. These disciplines can help prevent as well as evaluate and treat neuromusculoskeletal conditions as physician extenders, with OT limited to the upper extremity.

Additionally, OT and PT can provide evaluation and treatment for a wide range of developmental, neurological, or general medical conditions across the life span. These professionals can also assist in injury prevention, reducing morbidity, and decreasing the effects of disability through education using ergonomic principles. Occupational therapists are also involved in evaluation and treatment of chronic and acute MH conditions and serve as members of the CSC team.

(1) In nation and humanitarian assistance, these professionals can play a significant role in the development and implementation of health care programs. Based on evaluation, individual or group treatment programs for patients with amputations or nerve injuries serve to increase functional independence as well as improve quality of life and morale. Therapists are also skilled in teaching health care members from the HN. Occupational and physical therapists' training and experience allow them to evaluate, treat, educate, and prevent disability and injury across the life span (pediatrics to geriatrics).

(2) In any support operation involving deployment of soldiers, OT and PT support is based on anticipated patient work load (typically high orthopedic injuries and MH) and size of the medical element. Therapists work as primary care providers for patients with musculoskeletal problems. Prompt evaluation and treatment of these injuries enhances healing, expedites RTD, and helps prevent evacuation out of the AO. In addition to patient care, PTs and OTs serve as health/fitness and injury prevention consultants both to individuals and to units. Occupational therapists serve as members of CSC teams and provide activity-based, goal-oriented treatment for soldiers and civilians.

b. Nutrition Care.

(1) In stability and support operations, nutrition care programs can significantly reduce the effects of malnutrition from an inadequate diet in children and adults and also reduce morbidity. Dietitians can also have an impact in promoting healthy lifestyles by designing and implementing education programs to teach local residents to prepare healthy meals from locally available foodstuffs. Programs can also be developed to enhance nutritional support and dietetics within the hospital setting by—

- Establishing standardized menus and diets.
- Providing patient counseling and developing individualized diets for specific medical conditions.
- Teaching the use of modified diets.
- Providing hands-on training to hospital food service staffs in the preparation and serving of patient meals.

(2) In humanitarian assistance operations, nutrition care services may involve the refeeding of a healthy population or working with an indigenous malnourished population. Nutrition care services may be provided directly to the HN population or indirectly through HN dietetic programs. An example of direct assistance is the planning for and providing of special diets to HN civilian casualties or advising HN care providers on nutrition support for wounds, injuries, or diseases. Assistance can also be provided in assessing the nutritional status of the general population and recommending ways to achieve optimum

nutritional levels of locally available food stuffs. An example of indirect assistance is serving as a consultant to the HN medical education system in the development of nutritional care specialists and of nutritional programs for children and adults.

(3) In disaster relief operations, nutrition care services involve the feeding of disaster victims, rescue workers, and caregivers. Dietitians and hospital food service specialists can assist in assessing, planning for, and implementing centralized feeding sites for victims left homeless or without the ability to prepare their own meals and for the disaster relief workers. Nutrition care specialists can also assist in planning for and implementing food distribution centers for victims. Further, they can assist or augment local civilian hospital operations by assessing and providing specialized nutrition care to patients.

c. Nursing Services. Within the nursing profession, there are a number of nurse practitioners, such as nurse midwives. These resources can be used to provide direct patient care to a HN population or can serve in a teaching/consulting role in the development of educational programs for both the HN population and the HN health care providers. Additional nursing specialties, such as community health nurses, can also be used to develop educational programs and provide direct patient care and consultation. For example, a community health nurse could develop a maternal and child health care program and establish a well-baby clinic.

d. Pharmacy. Pharmacy personnel can be employed in some operations in a consultative role to assist HNs with the development of the pharmacology system within a hospital and to enhance training of pharmacy support personnel. Assistance could be provided in such areas as inventory control and requisitioning; controlled substance handling, storing, and distribution procedures; establishment of admixture programs; and formulary preparation.

e. Radiology. As modern technology continues to surge forward, the field of radiology becomes more complex and diverse. State-of-the-art equipment and comprehensive diagnostic studies require continuing education and training to keep pace with new developments. Many countries do not have as sophisticated radiology equipment as the US. Developing countries need assistance and training in the use of new equipment and the diagnostic studies that can be accomplished with this equipment as they upgrade their capabilities. Consultation and the development of programs for education and training will run the gamut from relatively austere field equipment to state-of-the-art diagnostic equipment. A needs assessment must be accomplished to determine what capability is available and the areas in which the HN wants to expand and enhance its capability.

f. Optometry. Optometry services provide eye examinations for eyeglass prescriptions so that optical fabrication elements supporting stability and support operations can make corrective eyewear. Further, optometrists have specialized equipment that can be used to identify eye injuries and infections which require referral.

4-7. Hospitalization and Medical Treatment in Support of Stability and Support Operations

In many stability and support operational scenarios and missions (such as attacks and raids or counterdrug operations), the deployed force receives CHS in the traditional manner. The CHS force is task-organized to

provide the support required for the operation. As these operations are normally of short duration, the focus of the care provided is EMT and ATM, with hospitalization provided by a designated facility outside of the AO. However, in other operations, nontraditional methods of health care delivery are required or consultative and instructional roles may predominate.

a. In NEO, EMT is provided to the NEO force and the evacuees by the medical element accompanying the force. Hospitalization support is provided by the hospital(s) designated to support the mission. These MTFs are not located in the AO, but rather are located in an ISB or safe haven where patients are medically evacuated to once they are extracted from the AO.

(1) The NEO force should maximize the use of medical personnel among the evacuees to provide routine care and to monitor any sick, injured, or wounded evacuees.

(2) The evacuation notice given to the evacuees prior to the arrival of the NEO force should specify that the evacuees bring special medications and eyewear with them. Depending upon the METT-T, a number of days of supply of medications can be recommended; however, this is no guarantee that the evacuees will have that many days of supply in their possession. (The evacuation notice is prepared and distributed by the embassy. Coordination for including information in the evacuation notice must be accomplished prior to deployment.)

b. In domestic support operations, medical care, treatment, and hospitalization requirements for each specific operation will be unique.

(1) Determining factors include the type of activity being conducted, capability of the local community, geographical location of the incident/mission, medical threat, magnitude of the operation (local versus state or federal), and the anticipated patient work load. The support provided can range from routine CHS to forces employed on law enforcement operations to on-site triage, treatment, and hospitalization of disaster victims. A medical force package may be task-organized to the specific situation, such as an Echelon II medical company providing on-site triage and treatment, augmented with a surgical capability to stabilize nontransportable disaster victims for evacuation out of the AO; or, it could entail support provided by a fixed MEDDAC located in proximity to a mass casualty situation (such as a gas line explosion in the local community) where the MEDDAC provides trauma care in its facilities to the victims.

(2) Specific guidance, authority, and legal advice should be obtained prior to implementation of these operations to ascertain who are eligible beneficiaries, what specific support can be provided, and where funding and/or reimbursement can be obtained.

c. Humanitarian assistance operations involve direct patient care activities or consultative and instructional assistance. In many humanitarian assistance operations, treatment elements are deployed to the AO and the patients are treated at that location. In most of these operations, medical cases requiring long-term comprehensive care are not undertaken; cases which can be treated and supported by the HN are the more likely focus of these operations. If patients require evacuation to a hospital facility, the facility concerned would most probably be a HN facility rather than a US military one. Some humanitarian assistance operations may entail the delivery of health care to hospitalized patients. This may take the form

of consultative services between surgical specialties and the HN medical staff, or direct patient care where specialists are there to perform certain specific types of surgical procedures.

d. In disaster relief operation, the requirements for military hospitalization support will depend upon the type of disaster, the extent of damage to the local medical infrastructure and the availability of services within the locality, the numbers of individuals requiring medical care, and the expected duration of the required support. For example, if a disaster occurred in an isolated locality, the number of patients requiring support would not reach the numbers affected in a disaster that occurred in a metropolitan area. However, due to the isolated geographical area, medical care and hospitalization facilities may not be available; significant field medical resources may be required to be deployed to the area. On the other hand, in the metropolitan area, large numbers of casualties may be generated; however, there may be sufficient medical resources that were unaffected by the disaster in other areas of the city. These unaffected resources may limit the need for deploying field medical units to the disaster site. In these operations, the key ingredient for managing the hospitalization and treatment aspects is to conduct a comprehensive on-site assessment to determine what resources are available and what resources are required.

e. In combatting terrorism operations, hospitals and other MTFs must have contingency plans for mass casualty situations (Appendix J) and for the evacuation of the patients under their care if they become the target of a terrorist incident.

(1) Hospitals normally have plans for the conduct of mass casualty operations and periodically conduct rehearsals of these plans. These plans can be implemented, if required, in combatting terrorism operations should a terrorist incident occur which generates sufficient casualties to overwhelm the available medical resources. Considerations for this plan include—

- Establishing triage and treatment areas.
- Activating a control element and personnel support pool.
- Limiting access to the facility through the use of barriers to canalize entry and exit points.
- Screening personnel entering and exiting the facility.
- Establishing medical response teams to deploy to the incident site, if required.
- Coordinating with other medical facilities in the area to disperse casualties in order to enhance patient care.

(2) In some stability and support operational scenarios, terrorist incidents may occur in areas where hospitalization assets are not available. Available medical resources within the community would stabilize the casualties for evacuation out of the immediate AO for the required hospital care.

(3) Contingency plans for the dispersion and transfer of patients and the treatment and hospitalization of new casualties is also required in the event the hospital and/or treatment facility is the object of the terrorist attack.

f. In peace support operations, the medical treatment and hospitalization mission, for the most part, remains that of providing traditional CHS to the deployed forces.

(1) The beneficiaries of this support may include other Services, allies, or coalition forces and US government civilians and contractors, and UN officials. The CHS commander/surgeon should receive legal guidance in determining what categories of personnel are eligible for care.

(2) The size of the deployed force, anticipated duration of the operation, the evacuation policy, and the anticipated level of hostilities determines the size of the medical element. Initially in most peace support operations, the medical element is task-organized to provide routine sick call, EMT, ATM, and PVNTMED. Patients with serious or life-threatening diseases, injuries, or wounds are stabilized for evacuation and evacuated to a supporting hospital outside of the AO. As the duration of the operation lengthens, augmentation with other services such as CSC, PT, or OT may occur. However, peace support operations often have fixed troop ceilings which limit the ability to expand services within the AO. Hospitalization support will normally not be available in the AO.

g. In support of insurgency operations, the medical infrastructure of the insurgent forces is usually austere or rudimentary. Besides providing direct patient care to the insurgents and their families, programs for training combat medics and other health professionals and establishing a limited hospitalization capability are required. This type of mission is usually conducted by SOF personnel; however, augmentation with conventional CHS personnel may be required.

Section IV. PREVENTIVE MEDICINE

4-8. General

Preventive medicine efforts require close planning and coordination between PVNTMED personnel, command surgeons, and unit commanders to identify all medical threats, define goals, promote PMM, and prevent duplication of effort.

a. Environmental injuries and diseases, field hygiene and sanitation, and other PVNTMED concerns impact on the health of US forces employed in stability and support operations. The forces employed are often small independent units with limited personnel. In stability and support operations, the occurrence of DNBI and environmental injuries create combat noneffectiveness and can adversely affect the success of the mission.

b. In furthering US national goals and objectives, military PVNTMED can be a major contributor to any US effort in stability and support operations. The very nature of military PVNTMED is conducive to the types of activities that support US policy objectives.

4-9. Medical Threat

a. General. The medical threat is traditionally evaluated for its impact on US forces and US military operations. In stability and support operations, it must also be assessed in terms of its impact on the HN and its people or the supported insurgent forces. Stability and support operations often occur in developing nations where endemic and epidemic diseases are prevalent. The medical threat is the driving force in the development of effective PVNTMED programs.

b. Arthropodborne Diseases.

(1) Few military personnel are aware of the magnitude of the medical threat posed by arthropodborne diseases. These diseases are transmitted through the biting process of arthropods or by the physical transfer of disease-causing organisms. Combat health support planners and personnel operating in areas OCONUS must be aware of the total worldwide threat, as well as the specific threats in areas of potential and planned operations.

(2) In stability and support operations, the level of sanitation, measures employed to control disease vectors, and the resources available to prevent and treat arthropodborne diseases varies. It must be remembered that US forces operating OCONUS are a highly susceptible population and are, therefore, at an increased risk.

(*a*) In disease-endemic areas, the native population may appear fairly healthy. They can actually harbor subclinical infections of the disease, having been exposed to repeated infections since birth. The pathogen is kept at a low enough level by the host immune system that it is unable to break out as a serious clinical disease. This smoldering infection can be present at levels transmissible to US forces. United States forces may be completely devoid of immune protection from a specific disease. Once they are infected by the pathogen, it can reproduce unchallenged. This results in an individual who is no longer effective in accomplishing his mission. Further, a portion of the limited medical resources available must be allocated to his care, treatment, and possible evacuation.

(*b*) Depending on the mission, the resources required to treat large areas for the control of arthropods may not be available. United States forces must use PMM to prevent contracting arthropodborne diseases. These measures include—

- An arthropod repellent system (consisting of a topical skin repellent and clothing impregnation material).
- Insect netting.
- Aerosol insecticides.
- Periodic checks (using buddy method) for ticks or other visible parasites.

(3) During protracted conditions of conflict or resulting from natural or man-made disasters, areas of a country previously endemic but now free of diseases (such as malaria, yellow fever, or plague)

can expect a resurgence of these diseases. Naturally occurring diseases that have been unnaturally excluded from an area through public health controls can gradually reappear when conflict or disaster disrupts these controls. Disruption of these controls can occur due to such things as a shortage of—

- Pesticides and arthropod repellents.
- Fuel to run public health equipment and vehicles.
- Supplies of treatment drugs, immunizations, and chemoprophylaxis agents.

c. Foodborne and Waterborne Diseases.

(1) In areas of poor sanitation, locally procured foods pose a high risk of disease for stability and support operations forces. United States standards for food preparation are often absent. Food handlers are frequently carriers of diseases readily transmitted through prepared food.

(2) Potable drinking water is often scarce in stability and support operations. Forces deployed cannot be assured of the safety or quality of local water supplies. Locally purchased ice poses the same health risks as food and water.

(3) The risk of foodborne and waterborne diseases to stability and support operations forces can be minimized by command enforcement of basic PVNTMED principles.

(*a*) The risk of experiencing a foodborne illness must be weighed against the impact on relationships with HN personnel. Refusing to eat with your host may be considered an insult; more harm than good may be done to the mission by your refusal.

(*b*) If possible, eat food prepared by US military food service personnel; when not available, maximize the use of meals, ready to eat (MREs).

(*c*) Only drink water that has been treated to US military standards. Do not use locally prepared ice. Ensure adequate water disinfection supplies (iodine tablets and calcium hypochlorite) are available. Exercise caution when drinking unopened bottles or cans of locally produced soft drinks purchased on the economy.

(4) Commanders should be alert to the possibility of terrorist attacks on or contamination of US military water sources. Possible targets include water treatment plants and equipment, reservoirs, and water distribution systems.

(5) Use of local water treatment facilities may provide needed water sources for stability and support operations forces. Such facilities may require upgrades to meet US drinking water standards. In all cases, they must be monitored closely and continuously by PVNTMED personnel.

(6) The CHS commander/surgeon must ensure that PMM, guidance on proper distribution of field sanitation equipment, and cross-training personnel are planned for and task-organized as appropriate.

In predeployment briefs, the CHS commander/surgeon must continually emphasize these points to the TF commander and senior leadership.

d. Environmental Injuries.

(1) Heat injuries can quickly diminish the effectiveness of a force. The commander must enforce a liberal water consumption policy. Further, he must ensure that soldiers consume an adequate number of meals. Food intake is required to prevent the loss of calories, salt, and minerals through sweating. Until soldiers are acclimatized and whenever possible, operations should be conducted in the cooler parts of the day to lessen the risk of heat injuries.

(2) Cold injuries are preventable. Commanders must ensure that soldiers are informed about the risk of cold injury. Further, they should be provided proper protective clothing and warming areas. This is important for soldiers who are exposed to the cold when their activity level is at a minimum such as when performing guard duty. Dehydration also increases the risk of cold injury. The commander, therefore, must ensure that a liberal water consumption policy is enforced.

(3) Injuries from exposure to industrial and occupational hazards pose a significant threat to soldiers in stability and support operations. Hazards from chemical substances arise from excessive airborne concentrations of mists, gases, vapors, fumes, or particulate matter, or contact with toxic liquids or solids. The toxic effects may be caused by exposure via inhalation, ingestion, or eye and skin contact. Early recognition of potential hazard areas is key to soldier protection. Since the disruption or abandonment of industrial facilities in Third World countries can generate chemical hazards, these areas should be avoided, if possible. When this is not possible, appropriate protective measures must be employed to reduce the soldiers' exposure. Preventive medicine personnel can provide command surgeons and all commanders with valuable assistance and guidance when dealing with industrial and occupational hazards. Particular care should be taken when using existing or abandoned buildings as bivouac areas or headquarters as these may contain indoor air contaminates (such as lead or asbestos). Further, the land surrounding industrial complexes may also be contaminated and present a potential hazard when used for storage or bivouac areas (such as fumes or vapors trapped inside tentage).

4-10. Preventive Medicine Support to Stability and Support Operations

a. Noncombatant evacuation operations may present unique PVNTMED considerations. While hostilities may or may not be a part of the operation, the very requirement for evacuation indicates there is a disruption of normal services. Breakdowns in the normal sanitary conditions, waste disposal, and provision of health care may occur. Congregation of large numbers of personnel in limited spaces awaiting evacuation may aggravate these conditions. Measures may need to be taken to prevent the transfer of exotic diseases to CONUS. Predeployment training on field sanitation, arthropod repellent use, and personal hygiene measures can increase the effectiveness of PVNTMED.

b. Preventive medicine resources may be used to support federal, state, or local domestic support operations when authorized. This assistance may be provided in the following areas:

(1) *Disaster assistance*. In the aftermath of man-made or natural disasters, the disruption of public works and waste disposal may create an environment for the rapid increase in the number of disease vectors (rodents and arthropods). Preventive medicine personnel can provide guidance on the control of these vectors through pest management practices. Further, PVNTMED personnel can—

- Provide guidance and assistance in restoring public health services.
- Conduct epidemiological investigations.
- Prepare and present educational programs in field hygiene and sanitation to victims of the disaster.

(2) *Environmental assistance*. Preventive medicine services may be requested by the local community when a hazardous material spill occurs or when unexplained contamination is found in surrounding wells or community water systems.

(3) *Community assistance*. Preventive medicine personnel may participate in community activities, such as public health programs, to provide educational presentations on disease vectors, epidemiological investigations, and PMM.

c. The PVNTMED role varies in foreign disaster relief and humanitarian assistance depending on the type of mission, location, and duration of the support. United States Government agencies (such as the DOS or the USAID), in coordination with the HN, will take the lead in these activities. United States Army PVNTMED personnel will support ongoing activities.

d. The terrorist threat may include the intentional contamination of food and water through the use of NBC agents. (Veterinary personnel inspect food for wholesomeness and quality.) As such, PVNTMED and veterinary personnel may be the best qualified to—

- Evaluate such threats.
- Carry out surveillance.
- Conduct analysis and testing of suspect food and water.
- Provide guidance for handling and decontaminating food and water.

e. Peacekeeping forces are generally under strict troop ceilings and operate with an austere logistical support structure. It is essential, therefore, that a complete assessment of the medical threat be done. This assessment ensures that the CHS assets are adequate for the needs of the deployed forces. Command emphasis on PMM is essential and these measures should be included in predeployment training. The actual combat wounds which will be incurred in these operations are minimal. Disease and nonbattle injuries and environmental injuries will have the most impact on these forces. The majority of these conditions are preventable. Early refresher training and command emphasis on PMM will decrease the medical threat effects to the peacekeeping force.

f. The type and comprehensiveness of PVNTMED support for an insurgency depend on the needs of the insurgent movement and the legal authority to provide the support. For the insurgent forces, the incidence of DNBI can be very high and can significantly reduce their combat effectiveness. The health risk to the insurgents is due in part to their limited number of personnel, austere logistical system, limited health care infrastructure, tactical conditions, environmental conditions, and disease prevalence. It is also influenced by their field sanitation and personal hygiene practices. A second aspect of insurgent support is concerned with the civilian population. As insurgent forces gain control over sections of the country, they may need to provide basic services to the population that can no longer be provided by the local government. In this case, the effort is to assist in providing public health and sanitation measures.

g. Preventive medicine support for counterinsurgency operations can focus on the HN military organization or on the civilian populace.

(1) *Host-nation military*.

(*a*) Preventive medicine support for the HN military can take several forms and should be conducted in a phased approach.

- The medical threat facing the HN military is evaluated and the PMM to counter these threats are determined.
- An assessment of the HN military's capability to implement the required PMM is completed.
- A PVNTMED plan is developed.
- The chain of command must be actively involved to continue and institutionalize the programs.

(*b*) The types of programs which can be developed include—

- Field sanitation and personal hygiene training (FMs 21-10 and 21-10-1).
- Immunizations.
- Nutrition and food sanitation training.
- Water purification.
- Disease and injury surveillance.
- Training a cadre of HN PVNTMED specialists to continue programs once US support is withdrawn.

(2) *Host-nation civilian population.*

(*a*) Because many of the health problems in developing nations are conducive to public health and PVNTMED solutions, US military PVNTMED assets can play a significant role. When the plan is implemented, HN participation is essential. Host-nation participation uses the local experience and expertise and ensures that programs developed are correctly implemented. This participation also ensures that the programs are not contrary to local political, economic, social, religious, and cultural practices and beliefs.

(*b*) Programs which can reduce the health risk and enhance the health status of the population include—

- Establishing a disease surveillance program for identification and early detection of arising health problems.
- Developing potable water systems.
- Introducing pest management methods and procedures.
- Enhancing or establishing waste disposal procedures.
- Enhancing maternal and child health care and nutrition education.
- Administering immunizations.
- Applying other programs using the full gamut of PVNTMED expertise and experience.

(*c*) The PMM and programs must be fully integrated into other CHS and civil-military operations (CMO) (such as clinical, dental, veterinary, or engineering).

h. The role of PVNTMED in attacks and raids varies depending on the mission, the environmental conditions, and the forces deployed. Early PVNTMED involvement in the planning phase of the operation is essential. Assessment of the medical threat and its impact on the operation must be determined.

- Rapid response requirements and lack of time to acclimatize the troops to the environmental conditions (heat and cold) may play a significant role in the accomplishment of the mission.
- The impact of endemic diseases may be reduced due to the short duration of many of these operations.
- Soldiers must ensure they carry at least the minimum supplies of water purification tablets. In the event the normal resupply of water or extraction from the AO is delayed, the soldier may have to purify his own drinking water.

Section V. VETERINARY SUPPORT

4-11. General

a. The US Army provides veterinary support for all DOD activities and federal agencies (except for USAF food inspection on USAF installations). The veterinary capabilities required are diverse and comprehensive. These skills and abilities should be recognized in the formation of the country plan and the CHS portion of OPLANs.

b. Identified veterinary requirements usually come through the requesting Commander in Chief (CINC) surgeon's office as part of the theater health service support plan or as a separate initiative. The Plans and Policy Directorate (J5)/Operations Directorate (J3) staff routes requests to the subordinate command that has area responsibility or can best meet the requirements. Supporting commands, coordinating with the CINC surgeon's medical planner and the J3 staff prior to planning and tasking, help ensure that adequate veterinary support is provided.

c. Veterinary support can contribute to the success of CHS operations in stability and support operations by—

- Ensuring that subsistence and food sources are inspected for wholesomeness, quality, and sanitation. (Preventive medicine personnel inspect water sources.)
- Providing care to government-owned animals (MWDs, pack animals, and military mascots).
- Helping to improve the public health of the population with such programs as—
  - Vaccinations for the control of communicable zoonotic diseases.
  - Public health and sanitation training.
  - Training in food hygiene, safety, and inspection techniques.
  - Animal husbandry programs (when specifically authorized).

d. In stability and support operations, the interrelationship of human and animal health, disease transmission, and economics is often complex. It can affect the overall health status of the country. Livestock animals (horses, cattle, goats, and hogs) affect both the economy and public health. The care and immunization of these important resources merit attention in the planning and resourcing of humanitarian assistance operations. Consumable veterinary drugs and supplies necessary for care of livestock are not normally available through military supply channels. These supplies must be resourced and procured early in the mission planning and development phases of the operation.

e. Veterinary personnel must coordinate closely with PVNTMED personnel to maximize expenditure of limited resources.

4-12. Veterinary Support to Stability and Support Operations

a. In NEO, the number of military/DOD civilian pets to be evacuated determines the required veterinary support structure. It is assumed for planning purposes that any NEO will be of short duration; pets will accompany their owners or be evacuated on a separate military chartered flight. Further, no hot meals will be served to the evacuees until evacuation to a safe haven is complete.

(1) Pet evacuation will be limited to normal domestic pets to include dogs, cats, guinea pigs, and hamsters. Birds will be handled on a case-by-case basis. No exotic pets will be evacuated.

(2) Even though euthanasia of military pets is an option, historical experience highly discourages this COA. The military's public image would be severely tarnished.

(3) Military veterinarians must be present to—

- Administer all required vaccinations.
- Issue international health certificates.
- Coordinate with US Customs officials.
- Provide health and husbandry care as required.

(4) Planning for pet evacuation must also include required veterinary and husbandry support at any scheduled stopovers and at the point of debarkation.

(5) The use of chartered military airlift with in-flight veterinary support to evacuate military pets is the best COA if time, resources, and level of hostilities permit.

b. Veterinary support may be required in both domestic and foreign disaster assistance operations to ensure the quality and wholesomeness of the food supply. Food supplies used in disaster relief operations are usually quickly procured, often without proper specifications. These supplies normally approximate native or regional diets. Veterinary personnel ensure that only safe and wholesome food supplies are used. Further, in the aftermath of a disaster, such as a hurricane, there will be many animals (privately owned pets, livestock, or wild animals) wandering through the disaster site. Some of these animals may be injured or ill. Veterinary personnel are required to effectively deal with this problem for the safety of the disaster victims, rescuers, care givers, and the animals. Further, veterinary personnel can assist in the control of zoonotic diseases.

c. Security assistance operations normally consist of providing logistic support to a friendly or allied nation facing an imminent threat.

(1) If the logistic support includes transporting subsistence, there will be an increased demand to inspect this cargo for safety and wholesomeness. The conditions imposed by short-notice deployments

may stress food supplies due to the lack of refrigeration or other factors, thereby requiring additional inspections.

(2) The assistance provided may include MWDs or other government-owned animals. These animals require veterinary support to sustain them and to ensure they remain disease free.

d. Department of Defense support to counterdrug operations is an integral part of the national drug strategy and compliments the efforts of law enforcement agencies and HN governments. Veterinary support to counterdrug operations includes—

- Caring for the government-owned animals used in these operations.

- Assisting a HN in developing alternate forms of agriculture/livestock production to produce or increase revenue. This assists in decreasing their dependency on drug crops.

e. Veterinary personnel should be involved in the planning to counter the terrorist threat. Veterinary support may play a key role in antiterrorism. The terrorist threat may include the employment of NBC weapons. Veterinary personnel, therefore, must be alert to the potential use of these agents and report any suspected use to the appropriate authorities. Veterinary personnel are also needed to differentiate the normal deaths of animals from those potentially caused by terrorists using BW or CW agents. Personnel, animals, and food supplies and sources (such as crops) are highly susceptible to biological agents. Veterinary personnel must be prepared to inspect suspect subsistence and care for affected animals. Further, MWDs are trained to detect explosive materials which aid in the search of potential terrorist activities; these animals must be sustained.

f. Veterinary support is required in most peace support operations.

(1) Due to the nature of these operations, field expedient food procurement systems may be established. Veterinary assistance is essential to ensure that only safe food is procured.

(2) In these operations, MWDs may be required to perform many tasks (such as guarding areas and conducting bomb searches). Veterinary support is required to sustain the use of these and other government-owned animals.

g. Veterinary support to insurgency and counterinsurgency operations, humanitarian assistance, and nation assistance includes—

(1) Veterinary personnel that may provide training to supported insurgent forces in establishing a food procurement system, inspecting food, caring for MWDs and pack animals, and caring for and managing livestock.

(2) The use of veterinary resources and expertise in counterinsurgency operations includes support to US troops and assistance to HN military forces and civilians.

(*a*) The support of US troops is largely characterized by traditional services rendered by the veterinary personnel, such as—

- Treating government-owned animals.
- Ensuring the wholesomeness and safety of the US military food supplies.
- Ensuring the local procurement process for food items maintains adequate standards for hygiene, safety, and quality assurance.

(*b*) As CHS involvement increases, veterinary personnel can assist in the assessment of the HN's veterinary programs. Of particular note, SOF personnel are early participants in counterinsurgency operations and their medical assets (the Special Forces [SF] medic and attached veterinary personnel) are trained in the basics of animal husbandry and food inspection. Coupled with their basic animal and agriculture knowledge, language skills, and knowledge of the culture, they easily interface with the HN residents and can be effectively used to enhance HN economic stability. They can provide guidance, training, and treatment of the HN's military animal care program (pack animals, livestock, and MWDs). Further, the veterinary service can assist in establishing a food procurement system or in enhancing an already existing system.

(3) The US Veterinary Service's most challenging and nontraditional roles include nation assistance and assisting in establishing programs that benefit a HN's populace. Veterinary personnel participation in nation assistance activities must be thoroughly coordinated through the country team. Coordination with such agencies as the DOS, USAID, the US Department of Agriculture (USDA), and HN counterpart agencies may be required. (United States Army veterinary personnel are not members of the country team. Face-to-face coordination with relevant members of other US governmental and HN agencies, however, is indispensable if veterinary programs are to be successful.) The USAID is responsible for helping HNs improve their health care systems (including veterinary care). The USDA is often involved with the development of these programs. In many cases, these agencies are not on-site for executing programs, but rather contract with outside agencies for the actual implementation. The US military often has veterinary resources and the logistical support systems already in-country to execute and effectively promote such programs. Military veterinary personnel (after thorough research, coordination, and assessment of capabilities and resources) can develop COAs to support the overall veterinary effort.

(*a*) Well-developed veterinary programs can impact a wide range of interests (such as public health, medical, nutritional, and economic). These programs must complement the social, religious, and political factors present in the HN. Proposed veterinary programs require the development and evaluation of programs which address the specific problem areas that tend to foster an insurgency in a given region. For example, if the principal issue underlying an insurgency is a religious one, the application of a successful program to eradicate Brucellosis in goats will have little impact on the HN's ability to survive the insurgency. On the other hand, if the central dilemma is an expanding population without economic growth, the insurgent may base his strategy on the HN's inability to provide for the basic needs such as food, fuel, clothes, and housing. In this situation, the use of a program to control hog cholera on small farms would increase pork production. The control of this disease will have a direct result of increased food production, increased income for the farmer, and perhaps of most importance, the ability to change the diet

from one based on grain to one which includes meat. This improves the living status of the populace. Changes such as these directly attack the insurgent's principal issue, defuse the insurgent's psychological operations, and at the same time bolster the credibility and popular support of the HN government.

NOTE

Veterinary personnel must ensure the programs developed are in consonance with the local customs, values, and religious ideologies. For example: it would do no good to increase pork production in a Muslim or Jewish country, beef production in a Hindu country, or any of the above if the people are vegetarians.

(*b*) In developing, coordinating, and establishing US military veterinary support to the FID effort, several factors must be considered. The primary issue is to determine the specific veterinary support required. If the mission is a combination of activities, then priorities must be established. Once the mission is established, the level of veterinary resources available is determined. The planning considerations include—

- State of development of HN veterinary infrastructure.
- Accessibility and affordability of HN veterinary services.
- Human and animal disease prevalence data.
- Status of agricultural production systems.
- Determination of the local names for common diseases.
- Climatic factors (rainfall, temperature, dry and wet seasons).
- Soil factors (pH, deficiencies).
- Agriculture economics (market systems, cooperatives, banking).
- Infrastructure (roads, rivers, electric power).
- Availability of animal foodstuffs.
- Status of immunizations and chemoprophylaxis for livestock.

(*c*) The programs that are developed should focus on long-term projects. As stated in paragraph 3-6*b*, the *quick fix* should be avoided in this arena. However, there are a number of programs which can be developed and require only short-term US military involvement. These include—

- Vaccination programs in which single dose application provides lasting immunity.

- Village-level external parasite control facilities (dipping vat construction projects).
- Vampire bat control programs.
- Water well and windmill construction in selected areas to improve animal grazing capabilities.
- Local control of toxic plants on grazing lands.

(*d*) Long-term programs to improve animal health and increase production are optimal solutions for changing some of the environmental conditions. These programs are based on solid economic principles and include the phaseout of US assistance. Such programs must be developed after extensive evaluation by regional experts. Programs requiring active participation by local financial institutions tend to be extremely successful. They provide incentive and produce tangible rewards. An example would be a requirement by local banks for livestock production loans to have the producer feed mineralized salt and vaccinate the cattle against foot and mouth disease in order to secure the loan.

(*e*) Innovation and creativity are hallmarks of a successful nation assistance program. Veterinary support capabilities include—

- Assisting in veterinary laboratory development.
- Assisting in vaccine production development.
- Training HN or indigenous personnel in treatment and animal husbandry skills.
- Assisting in the development of drug and vaccine distribution systems.
- Assisting in the development of disease control and eradication strategies.
- Improving food plant sanitation.
- Conducting epidemiological surveys.
- Assisting in animal disease and parasite control.
- Developing food inspection systems.
- Developing education and exchange programs.
- Serving as advisors.

h. In all stability and support operational scenarios where the anticipated duration of the operation is sufficient to establish base camps of a semifixed nature, soldiers have a tendency to adopt local domestic and/or wild animals (such as the mongoose during the Vietnam War) as unofficial mascots. The command

should establish a policy and provide guidance on this issue prior to deployment. The unofficial mascot has the potential to be a significant medical threat in the transmission of zoonotic diseases to US forces.

Section VI. DENTAL SUPPORT

4-13. General

a. The dental role in stability and support operations ranges from traditional support to deployed US forces to dental programs in foreign humanitarian assistance and domestic support operations.

b. An in-depth discussion of the provision of dental support is provided in FM 8-10-19.

4-14. Dental Assessment

a. Dental assessment in advance of planning is important in understanding the dental health care needs of the population. Data, information, and medical intelligence should be combined with information provided by the diplomatic mission to the HN to determine dental requirements for the mission. If possible, personal observations by a dental officer should be accomplished. (Continued involvement or consultation with a dental public health officer is desirable.)

b. The senior dental officer should provide the assessment and recommendations to the command surgeon. These recommendations should include—

- Dental care goals and objectives.
- Concept of the dental operation.
- Manpower, materiel, and funding requirements.
- Standards of care.
- Milestones and time lines.

c. The early involvement of the supported HN government or insurgent forces is essential in the plan development process. Credit for the plan and its execution should always be given to the HN government or forces that are being supported.

d. Dental planning considerations may include HN resources such as—

- Military dental assets and capabilities.
- Dental schools.

- Government dental licensure authority.
- Nondental health care personnel who are or can be involved in dental programs, such as community health nurses.
- Civilian dental practitioners.
- Dental auxiliary training and use.
- Dental supply sources.
- Dental laboratories.
- Public health programs.
- Public and private school systems.
- Mechanisms for dental care financing.
- Water distribution system and potential for fluoridation.
- Commercial marketing of oral health products.
- Media capability for mass awareness programs.
- Religious organizations' involvement in social and health-related activities.

4-15. Dental Support to Stability and Support Operations

a. Dental support in US domestic support operations is limited. This is due to the well-developed dental infrastructure in this country. The primary role of US Army dental assets would be to reestablish and to augment the civilian dental infrastructure when it is temporarily disrupted by natural or man-made disasters or civil disturbances. In some circumstances, community assistance may be provided in remote locations for populations without reasonable access to dental care or on request from community-based prevention and education programs.

b. When approved by the NCA, there may be dental support to a variety of stability and support operational missions, such as humanitarian assistance or nation assistance. Modified dental support approaches may be required for these operations. The dental threat in developing nations includes oral infections and dental caries; a high prevalence of oral developmental conditions such as cleft palate; and maxillofacial injuries due to combat and noncombat injuries. These countries typically have an inadequate dental care infrastructure to prevent and treat these conditions. Dental programs and operations can be conducted in conjunction with other CHS operations or as separate activities.

(1) Direct delivery of care to HN populations in nation assistance operations is an easily implemented and highly visible display of support (credit for the support should be to the HN rather than to the US). It should only be considered as a short-term benefit. Dental support roles that provide a long-term benefit include—

- Conducting HN assessments to identify oral, dental, and maxillofacial needs and dental health capabilities.
- Assisting in building a dental support infrastructure.
- Encouraging oral health promotion and disease prevention programs.
- Assisting in developing a military dental capability to prevent and treat oral, dental, and maxillofacial conditions.
- Providing assistance in planning for forensic dental operations.

(2) Resources to accomplish these objectives are uniquely different from those required to treat US soldiers in the field. The CHS planner must ensure that an appropriate mix of specialties and required equipment is task-organized for the specific mission. Dental MESs may require augmentation with equipment for providing care to children and for treating a higher incidence of gum disease. Teaching aids and preventive materials may be required. These differences should be included in the planning process and adequately funded.

(3) The limitation on resources may significantly influence the level of care or scope of treatments, but there are certain standards for care that cannot be compromised. For example, these may include infection control, qualifications of the care provider, selection of procedures, and standards required by HN law. The factors affecting the scope of practice include lack of funding, inaccessibility of remote locations, and shortage of equipment and supplies.

c. More traditional military dental support may be required for US and HN troops in shows of force, peacekeeping operations, peace enforcement, and attacks and raids.

Section VII. COMBAT STRESS CONTROL AND MENTAL HEALTH SERVICES

4-16. General

a. Stability and support operations may have brief periods of extreme violence or prolonged periods of inactivity. These conditions can produce classic BF. The operations may even involve NBC threats which add the psychological and physical stressors of mission-oriented protective posture (MOPP). However, the more usual stressors are those of frustration, resentment, loneliness, and boredom. These

stressors come from being in an unfamiliar land far from home; having limited privacy; being among unfamiliar and perhaps hostile people; and operating under restrictive ROE. There is also often ready access to drugs and alcohol from local sources. Enemy tactics attempt to magnify these stressors and to provoke misconduct stress behaviors. These behaviors (such as insubordination and abuse of power) can turn the local population against the US.

b. The HN may have rudimentary concepts and resources for psychiatric care, MH promotion, and social services delivery. These limitations could be the focus of enhancing the HN government's stability, but only if cultural differences are fully taken into account.

c. Combat stress control and MH personnel have provided commanders with effective service in many previous stability and support operations. They have and will continue to provide MH support to all activities in stability and support operations. For example, MH personnel—

- Provided support to soldiers in Vietnam and more recently in Somalia, Haiti, and Bosnia.

- Provided stress control for US personnel and psychiatric inpatient and outpatient care for Cuban and Haitian refugees at Guantanamo, Cuba.

- Were members of numerous peacekeeping TFs assigned to the Middle East.

- Organized stress management teams which provided assistance to soldiers, civilians, and family members exposed to terrorist actions, or natural or man-made disasters.

- Advised a friendly government in the prevention and treatment of stress casualties among its military and paramilitary forces.

d. The stress control assets in stability and support operations are task-organized and may include elements of the MH sections of division units, area support medical battalions (ASMBs), and corps CSC detachments and companies. The neuropsychiatric personnel of hospitals can also be used to provide proactive stress control interventions. United States Air Force and USN MH assets in theater should also be identified and coordination accomplished when required.

e. For further information on CSC, refer to Appendix O of this manual, FM 8-51 and FM 22-51.

4-17. Combat Stress Control Support to Stability and Support Operations

a. Stress management teams are an integral part of the military's approach to helping personnel involved in combatting terrorism operations. The team's mission is to support rapid return to effectiveness and to preclude post-traumatic stress disorders in captives and those persons closely associated with a terrorist activity. This team is a multidisciplinary group and should be on call to rapidly deploy to a selected site. Experiences with the bombing of the Beirut US Marine Corps Force, the Oklahoma City Federal Office Building, the Kohbar Towers in Dhahran, and other incidents have demonstrated the requirement for

stress management teams. The prevention and treatment principles and approaches parallel those used in the treatment of BF.

b. Selected MH staff should accompany US peacekeeping TFs. Historically, these TFs require reinforced organic logistics and CHS. Mental health staff have been used effectively to support a variety of peacekeeping missions.

- Mental health officers can assist commanders in—
  - Completing predeployment unit effectiveness surveys.
  - Providing training and consultation related to stress management and unit cohesion.
  - Completing MH screenings and evaluations on all soldiers during pre- and post-deployment and on selected individuals during deployment.
  - Conducting predeployment family support briefings.
- During peacekeeping operations, the focus is on MH assessment and consultation.

c. Mental health activities in support of insurgency and counterinsurgency operations are designed to meet specific missions. As the level of combat intensity and the duration of the mission increase, combat stress-related problems also increase. It is expected that BF rates will not normally exceed 1:10 per WIA. Organic MH staff use the combat stress principles of proximity, immediacy, expectancy, and simplicity in treating BF soldiers. However, the main problem will be misconduct stress behaviors. These misconduct stress behaviors can include substance abuse, acts of indiscipline, and some criminal acts. Misconduct stress behaviors may seriously interfere with the stability and support operational mission unless prevented. It is expected that soldiers will suffer from adjustment reactions, endemic psychiatric disorders, and drug and alcohol abuse.

d. Due to the limited duration of most NEO, CSC personnel will not normally accompany the deployed force. However, once the NEO force and the evacuees reach the ISB or safe haven, CSC interventions in the form of after-action debriefings may reduce the incidence of stress-related problems.

e. Mental health assistance may be required in some domestic support operations. Mental health activities (preventive measures and acute interventions) may be used to manage stress-related problems/reactions arising from traumatic experiences (such as natural or man-made disasters or a singular incident such as a school bus accident which results in the deaths of or serious injuries to the students). The adverse effect of the stress not only affects the victims of the incident but also family members, friends, rescue workers, and care givers. Critical incident stress debriefings (for victims, families, and friends) and after-action debriefings (for care givers and rescuers) enable the victims/participants to express their feelings, gain perspective from others involved in the experience, and to better understand the incident and their feeling concerning it. These activities may reduce the incidence of post-traumatic stress disorders in this population.

Section VIII. COMBAT HEALTH LOGISTICS

4-18. General

a. Combat health logistics plays a significant role in the delivery of health care in stability and support operations. As most missions in stability and support operations are conducted within an immature theater, the full complement of logistics capabilities and services may not be in place. The CHL planner must be flexible and innovative to be able to bridge the gap between requirements generated by the operation and the capability to provide the necessary Class VIII supplies and equipment.

b. In order to ensure that the correct mix of medical supplies and equipment is obtained, the command surgeon must coordinate his specific requirements with the CHL element.

c. The CHS commander is responsible for ensuring that medical and industrial waste generated by CHS operations is correctly handled, transported, and disposed of according to applicable regulations, agreements, and laws. Improper management of these wastes may adversely impact the health of the deployed force and local population.

d. In joint operations, the major subordinate US Army CHL agency may be appointed as SIMLM which is the DOD Executive Agent for all Class VIII supplies and equipment. This necessitates the early involvement of the CHL planner in the planning process. For additional information on the SIMLM, refer to Joint Pub 4-02.

4-19. Combat Health Logistics Support to Stability and Support Operations

a. Prior to the deployment in NEO, the senior medical person accompanying the force determines if there are any special medical supply or equipment requirements which the deploying force must take along to provide continuous medical support to the evacuees. For example, if a significant number of evacuees will be infants and children, MESs must be augmented with pediatric medicines and medical equipment. Under most circumstances, the Class VIII supplies and equipment the force brings with them is all that they will have to operate with. In a permissive NEO, it may be possible to obtain some medical supplies and equipment locally, if the available supplies meet with US medical supply standards. (Medical equipment purchased locally may not be able to be maintained due to nonavailability of repair parts within the CHL systems. It should be purchased for a one time use only.) Caution must be exercised when acquiring medical equipment locally, as the equipment may not be approved for use aboard USAF aircraft.

b. In disaster assistance operations, the management of Class VIII supplies and equipment is critical to the successful completion of the support operation.

(1) A task-organized CHL element is established to provide for the management, receipt, sorting, storage, repackaging, distribution, and accounting for donated medical supplies and equipment. It is also responsible for the requisition, receipt, and accountability of Class VIII resources required which cannot be met through donated materiel. Normally within a disaster area, there is no one organization that

would accomplish this type of function. The medical supplies and equipment donated in relief operations come in all different types of packaging, sizes, and amounts. It must be received, sorted, repacked, and distributed to areas of need. A task-organized CHL element can provide this necessary support.

(2) An assessment of the disaster area (to include coordination with other agencies/countries providing assistance) must be accomplished to determine what types and quantities of supplies and equipment are available or are anticipated to be donated, and how many customers the element will support.

(3) The size of the CHL element deployed is dependent upon the size and anticipated duration of the operation, the quantity of materials to be handled, and the number of customers to be supported.

c. In humanitarian assistance operations, the CHL planner must obtain and coordinate transportation, and receive, sort, store, and distribute Class VIII materiel. Depending upon the scope of the operation, there may also be donated medical supplies and equipment which must be handled, stored, and distributed. Due to the remoteness of the operational site in humanitarian assistance operations, the task of getting the supplies and equipment to the target location may be difficult. The CHL planner must consider the METT-T factors and the—

- Scope of the operation and its unique requirements.
- Availability of HN support.
- Availability of Class VIII supplies and services within the local community.
- Coordination requirements with non-DOD agencies, allies, coalition partners, HN, and religious and charitable organizations.
- Quantities and types of donated Class VIII materiel.
- Requirements for handling, repackaging, storing, and distributing donated materiel.
- Sources of funding for Class VIII materiel.
- Availability of structures for storage of materiel (to include refrigeration capability).
- Delivery mode and transportation requirements.
- Security and accountability of controlled substances.
- Cultural and ethical implications of certain medical items (such as blood and blood products).

d. In nation assistance programs, CHL personnel can assist a HN by conducting an assessment of the military CHL and civilian medical logistics infrastructures and industries.

(1) In many countries, a formal CHL system is not established or is rudimentary in nature. By establishing and institutionalizing this type of system, the HN can—

- Develop a usage history on Class VIII items.
- Develop a standardized formulary.
- Reduce costs by—
  - Purchasing in bulk.
  - Obtaining the best price through competitive shopping.
  - Establishing accountability procedures.
  - Managing stockage levels and cross-leveling inventories between MTFs.
  - Lessening inventory losses due to improper storage, inadequate refrigeration, and outdated medications.
- Identify critical shortfalls.
- Establish product specifications.

(2) Combat health logistics personnel can provide training and instruction in the numerous functional areas within this field. Assistance may be provided in such areas as—

- Materiel handling techniques.
- Storage requirements and techniques.
- Requisition procedures and formats.
- Control and accountability of medical equipment, supplies, and blood and blood products.
- Spectacle fabrication and assembly.
- Distribution techniques.
- Medical equipment set configuration.
- Stock rotation.

e. In peace support operations, the CHL mission is the traditional support to a deployed force. Due to the austere staffing and troop ceiling placed on many of these missions, the CHL element may be

restricted in size. Other than delivery of the materiel, the functions of receiving, storing, accounting for, requisitioning, repackaging, fabricating spectacles, and managing blood and blood products may be accomplished in another country or safe haven. Planning considerations include—

- Anticipated duration of the operation.
- Support available from allies, coalition forces, and HN.
- Size of the in-country element.
- Level of hostilities to be encountered.
- Delivery mode and transportation requirements.
- Number of customers to be supported.
- Design and maintenance of unique MESs to meet mission requirements.

f. Combat health logistics support for attacks and raids is primarily in the planning and preparation phases of these operations. Rapid insertion of combat forces and equally rapid extrication or reinforcement will not necessitate extensive resupply operations. Planning for CHL then focuses on the worst case of a force taking large numbers of casualties with delayed extrication or reinforcement. The command surgeon should consider the following issues and make recommendations to the tactical commander:

- Increase the number of dressings and bandages carried by the individual soldier. The current first-aid pouch will easily hold two dressings or a dressing and bandage.
- Have each soldier or every other soldier carry one 500 milliliters (ml) of IV fluid to treat dehydration or hypovolemia. (In cases of heat injury, if an IV starter kit is not available, the soldiers can drink the solution.)
- Develop a medical push package with emphasis on IV fluids, dressings, bandages, and splints, and with other components at the discretion of the command surgeon. Class VIII containers must be clearly marked and not include nonmedical items.

Section IX. MEDICAL LABORATORY SUPPORT

4-20. General

Depending upon the size of the force deployed, the specific mission to be accomplished, and the anticipated duration of the operation, medical laboratory assets may be employed in stability and support operational

scenarios. If the deployment includes deploying an Echelon II or above MTF in its entirety, then the organic medical laboratory assets will be deployed. However, in short-duration operations where the CHS element is task-organized for the specific mission, a medical laboratory may not be deployed. Any required medical laboratory support would be provided by a facility outside the AO.

4-21. Medical Laboratory Support to Stability and Support Operations

a. Medical laboratory services are usually not a factor in NEO. Medical laboratory personnel and equipment are normally not included in the task-organized medical element that accompanies the NEO force due to the short duration of these operations. If the AO is suspected of being contaminated with a BW or CW agent, NEO personnel should request assistance from the supporting PVNTMED team, chemical detection team, or in-theater laboratories which are trained to handle and identify BW and CW agents (such as the theater area medical laboratory [TAML]/area medical laboratory [AML] or USN land-based laboratory). In the absence of these supporting units, the NEO force should refer to FM 8-10-7 for instructions on the collection and management of specimens/samples contaminated with suspected BW and CW agents.

b. Medical laboratory capabilities will differ with the types of forces deployed in a given AO. As terrorist incidents can occur at any location, the supporting MTF must coordinate with the supporting PVNTMED team, veterinary team, or in-theater to obtain a full range of investigative services to identify suspected BW and CW agents and to test food and water for possible contamination.

c. Due to the sophistication of health services within the US, many medical laboratories throughout the nation have state-of-the-art equipment and are readily available. Community assistance and disaster relief assistance at the local level initially may require the use of organic medical laboratory capabilities of the military unit providing support. However, once a domestic support operation exceeds the local community level and the FRP is activated, the USPHS and the Centers for Disease Control have ready access to whatever level of sophisticated laboratory procedures/equipment they require.

APPENDIX A

ANTITERRORISM AND FORCE PROTECTION

A-1. General

Preventive and protective security measures should be taken by military units and individual soldiers to protect themselves and their ability to accomplish their mission while deployed. The commander develops an antiterrorism plan to institute passive defense measures. The commander must constantly evaluate security plans and measures against the terrorist threat in order to effectively identify security requirements.

A-2. Terrorism Considerations

a. As commanders and staffs address terrorism, they must consider several relevant characteristics of terrorists and their activities. The first consideration is that anyone can be a victim. (Some terrorists still operate under cultural restraints, such as a desire to avoid harming women, but the planner cannot count on that.) Essentially, there are no innocents. Secondly, attacks which may appear to be senseless and random are not. To the perpetrators, their attacks make perfect sense. Acts, such as bombing public places of assembly and shooting into crowded restaurants, heighten public anxiety. This is the terrorists' immediate objective. Third, the terrorists need to publicize their attack. If no one knows about it, it will not produce fear. The need for publicity often drives the target selection; the greater the symbolic value of the target, the more publicity the attack brings to the terrorists and the more fear it generates. Finally, a leader planning for antiterrorism must understand that he cannot protect every possible target all of the time. He must also understand that terrorists will likely shift from more protected targets to less protected ones. This is the key to defensive measures.

b. Medical units have specific protections afforded to them under the provisions of the Geneva Conventions. The CHS commander must understand that these protections probably will not be recognized nor adhered to by terrorist elements. The CHS commander in developing his force security plan should not consider the Geneva Conventions as a protection from attack by terrorist elements.

c. Terrorists rely on surprise and the victim's confusion at the time of the incident. Antiterrorism involves physical security, OPSEC, and the practice of personal protective measures by all personnel. Commanders and staffs must plan their response to terrorist threats and incidents. Combatting terrorism is an aspect of force protection and is the responsibility of commanders at all levels at all times. Properly planned and executed, the Army antiterrorism program will reduce the probability of surprise while discouraging attack by raising the risk to the attackers.

A-3. Estimate of the Situation for a Security Assessment

The commander and his staff should complete a thorough estimate of the situation, using METT-T and political planning factors, in developing a security assessment. The following questions (Table A-1) may assist in formulating the estimate.

Table A-1. Mission, Enemy, Terrain, Troops, Time Available, and Political Planning Factors

MISSION
1. WHAT TYPE OF MISSION IS TO BE CONDUCTED (SUCH AS HUMANITARIAN ASSISTANCE, NATION ASSISTANCE, DISASTER RELIEF, OR CONVENTIONAL CHS)?
2. WHERE IS THE MISSION TO BE PERFORMED (SUCH AS WITHIN A SECURE COMPOUND, IN LOCAL VILLAGES/CITIES, IN A FIELD ENVIRONMENT)?
3. IS THE ENTIRE UNIT OPERATING TOGETHER (SUCH AS ESTABLISHING A CLEARING STATION), OR ARE SEPARATE TEAMS BEING DEPLOYED TO REMOTE LOCATIONS (SUCH AS A TREATMENT TEAM VISITING AN ISOLATED VILLAGE)?
4. IS THIS A MEDICAL TF MISSION WHERE CHS UNITS ARE DEPLOYED PRIOR TO COMBAT AND CS FORCES?
5. ONCE DEPLOYED, DOES A CHANGE OF MISSION OCCUR?
ENEMY (OPPOSITION GROUPS, TERRORIST FACTIONS)
1. WHO ARE THE POTENTIAL TERRORISTS?
2. WHAT IS KNOWN ABOUT THE TERRORISTS?
3. HOW DO THE TERRORISTS RECEIVE INFORMATION?
4. HOW MIGHT THE TERRORISTS ATTACK? (THINK LIKE THE TERRORIST. WOULD YOU AMBUSH OR RAID? WOULD YOU USE SNIPERS, MORTARS, ROCKETS, AIR OR GROUND ATTACKS, SUICIDE ATTACKS, FIREBOMBS, OR BICYCLE, CAR, OR TRUCK BOMBS?)
5. DOES THE UNIT HAVE ROUTINES OR PUBLISHED OPERATING HOURS (SUCH AS STATED CLINIC HOURS FOR THE CARE OF HN PERSONNEL)?
6. WILL AN ATTACK GAIN SYMPATHY FOR THE TERRORISTS FROM THE POPULATION BEING SUPPORTED?
7. WHAT IS THE PERCEIVED TERRORIST THREAT POTENTIAL FOR VIOLENCE?
TERRAIN
1. WHAT ARE THE STRENGTHS/WEAKNESSES OF UNIT AREA AND LOCAL SURROUNDINGS?
2. WHAT ARE THE AVENUES OF APPROACH?
3. ARE THERE OBSERVATION AREAS, DEAD SPACES, FIELDS OF FIRE, ILLUMINATION, OR NO-FIRE AREAS?
4. ARE THERE TALL BUILDINGS, WATER TOWERS, OR TERRAIN, EITHER EXTERIOR OR ADJACENT TO THE PERIMETER THAT COULD BECOME CRITICAL TERRAIN IN THE EVENT OF AN ATTACK?
5. WHEN TEAMS MUST BE DEPLOYED TO OUTLYING AREAS TO ACCOMPLISH THE MISSION (SUCH AS PROVIDING HUMANITARIAN ASSISTANCE TO VILLAGES WITHOUT MEDICAL RESOURCES), WHAT IS THE CONDITION OF THE ROADS AND TERRAIN THAT MUST BE TRAVERSED (PAVED ROADS OR UNIMPROVED DIRT TRACKS) AND WHAT IS THE POTENTIAL FOR ATTACK WHILE IN TRANSIT?
TROOPS
1. DETERMINE WHAT THE FRIENDLY SITUATION IS.
2. ARE OTHER US FORCES AND EQUIPMENT AVAILABLE?
3. ARE ENGINEERS IN THE AREA? WILL THEY BE ABLE TO PROVIDE SUPPORT?
4. ARE MILITARY POLICE OR OTHER COMBAT/CS RESOURCES AVAILABLE TO PROVIDE FORCE PROTECTION FOR MEDICAL UNITS?
5. ARE THERE MWD TEAMS AVAILABLE TO CONDUCT SEARCHES FOR EXPLOSIVE MATERIALS IN THE UNIT AREA?
6. WHAT ARE THE HN'S RESPONSIBILITIES, CAPABILITIES, AND ATTITUDES TOWARD PROVIDING ASSISTANCE?
7. WHAT ARE THE ROE?

Table A-1. Mission, Enemy, Terrain, Troops, Time Available, and Political Planning Factors (Continued)

TIME
1. WHAT IS THE DURATION OF THE MISSION? 2. ARE THERE TIME CONSTRAINTS? 3. WILL THERE BE SUFFICIENT TIME TO CONSTRUCT FORCE PROTECTION FACILITIES (SUCH AS BARRIERS AND FENCES, AND THE INSTALLATION OF LIGHTS)?

POLITICAL PLANNING FACTORS
1. ARE THERE HN CONCERNS OR ATTITUDES WHICH WILL IMPACT ON THE SITUATION? 2. WILL THE SITUATION BE INFLUENCED BY THE EXISTENCE OF ANY RELIGIOUS, ETHNIC, OR CULTURAL CONCERNS? 3. IS THE ACCOMPLISHMENT OF THE CHS MISSION ALLEVIATING PART OF THE REASON FOR THE UNREST WITHIN THE COUNTRY (SUCH AS BETTER ACCESS TO HEALTH CARE OR CURBING MORBIDITY AND MORTALITY RATES FOR CHILDREN)?

A-4. Force Protection and Security Measures

a. Force protection is a complex process in which each action impacts upon many others. Planning for force protection is a continuous process. Force protection in stability and support operational scenarios can pose significant challenges.

b. The CHS commander is responsible for providing security for his unit and the patients under his care. In some scenarios, a combat or CS unit may provide security forces to assist in the defense of CHS units. In other situations, the CHS unit may not be collocated with other types of CSS units and the CHS commander must then provide completely for his own security.

c. In stability and support operations, medical units may be deployed into a given geographical area prior to the deployment of combat and CS forces. During humanitarian assistance and disaster relief operations, the perceived terrorist threat may be low, but the commander must ensure that his security measures are adequate for the appropriate threat level. Further, he must ensure he has the capability to increase these protective measures should the operational scenario change and mission creep occur. If the political, social, or economic status of the HN or region deteriorates, an increase in the potential for terrorist activity may also be experienced. The CHS commander must continuously evaluate the potential for terrorist activity and adjust his force protection plan accordingly.

d. Unit and individual protective measures are discussed in detail in Joint Pub 3-07.3.

APPENDIX B

INTERAGENCY OPERATIONS

B-1. General

a. Interagency operations facilitate unity and consistency of effort, maximize use of national resources, and reinforce primacy of the political element. Interagency operations involve many of the US government agencies, such as the DOS and the USAID. Interagency operations facilitate the implementation of all elements of national power and provide a vital link uniting the DOD and other governmental agencies.

b. Interagency operations can also include international organizations, agencies of foreign nations, public and private charitable agencies, and religious organizations.

B-2. Unity of Effort

Military commanders and their agency (civilian or governmental) counterparts will have to create *ad hoc* organizations to integrate their efforts. They must reach agreement on missions and allocation of resources through negotiation. Military officers cannot exercise *command* under these circumstances. Instead, they must persuade and compromise, employing their leadership skills, knowledge, and the force of their logic. When agreements are reached, they should be recorded in memoranda of understanding, terms of reference, or other similar documents. Although such agreements are usually reached at the highest levels of command, it is also likely that local commanders and agency supervisors can make agreements for cooperation within their AOR. Commanders and staff officers must be cognizant of the legal restrictions on how funds, materiel, and personnel can be used. Therefore, they should consult with their Staff Judge Advocates throughout this process.

B-3. Operations Within the United States

a. The DOD may be required to work with other federal agencies on operations occurring within the US (such as disaster relief, community assistance, law enforcement, or counterdrug operations). The other governmental agencies may have the primary responsibility for the operation, while the DOD plays a supporting role. These agencies include, but are not limited to—

- *Department of Agriculture*. As the lead agency for food and fire fighting under the FRP, the USDA has significant responsibilities in disaster assistance operations. The US Forest Service (USFS), an agency under the USDA, is responsible for leading fire-fighting efforts as well as protecting forest and watershed land from fire.

- *American Red Cross*. The American Red Cross (ARC), under charter from Congress, is the US's official volunteer disaster relief agency. It has a major role in disaster assistance operations, having been designated as the lead agency for mass care under the FRP.

- *Department of Commerce*. The Department of Commerce (DOC) provides fire and weather forecasting as needed by the National Interagency Fire Center (operated jointly with the Department of the Interior [DOI]) or from a nearby weather forecasting facility. Through the National Oceanic and

Atmospheric Administration, it provides scientific support for response and contingency planning in coastal and marine areas.

- *Department of Education*. The Department of Education (DOEd) establishes policy for, administers, and coordinates most federal assistance to education. It supports information and planning for disaster and environmental assistance operations. The DOEd may also become involved in selected Army community assistance programs that address education and training.

- *Department of Energy*. The Department of Energy (DOE) is the FRP's lead agent for energy. It provides the framework for a comprehensive and balanced national energy plan through the coordination and administration of the federal government's energy functions.

- *Environmental Protection Agency*. As lead agency for hazardous material response under the FRP, the Environmental Protection Agency (EPA) has a significant role and responsibilities in both disaster and environmental assistance operations. It provides for a coordinated response by federal departments and agencies, state and local agencies, and private parties to control hazardous material spills.

- *Federal Emergency Management Agency*. The FEMA is the federal government's executive agency for implementing federal assistance to a state and its local governments. In most cases, it implements assistance in accordance with the FRP.

- *General Services Administration*. The General Services Administration (GSA) is the lead agency for resource support under the FRP. Having extensive expertise, both in contracting and providing services, GSA is an invaluable player in disaster relief and environmental assistance operations.

- *Department of Health and Human Services*. The DHHS is the lead agency for health and medical services under the FRP. The USPHS, an agency under DHHS, leads this effort by directing the activation of the NDMS. The DHHS is also responsible for assisting with the assessment of health hazards at a response site and the protection of both response workers and the general public.

- *Department of the Interior*. As a support agency under the FRP, the DOI provides support for disaster and environmental assistance operations.

- *Department of Justice*. The Department of Justice (DOJ) plays a significant role in law enforcement and counterdrug operations. The Drug Enforcement Agency (DEA) is the DOJ's lead agency for counterdrug operations. As the government's legal representative, the DOJ becomes involved in law enforcement operations, community assistance operations, and disaster and environmental assistance operations.

- *Department of Labor*. The Department of Labor (DOL), through the Occupational Safety and Health Administration, conducts safety and health inspections of hazardous waste sites and responds to emergencies.

- *Department of State*. The DOS advises the President in the formulation and execution of foreign policy. Its primary mission in the foreign relations arena is to promote the interests of the US

overseas. In this capacity, the DOS manages USAID and the US Information Agency. The DOS also has a support role in disaster and environmental assistance events or domestic counterdrug operations having international implications.

- *Department of Transportation.* As the lead agency for transportation under the FRP, the Department of Transportation (DOT) coordinates federal transportation in support of federal agencies, volunteer agencies, and state and local governments.

- *Department of Treasury*. The Department of Treasury, through its agency the US Customs Service (USCS), regulates goods, people, and vehicles entering or leaving the US and its territories.

- *National Weather Service*. The National Weather Service (NWS) predicts, tracks, and warns of severe weather and floods.

- *National Communications System*. The National Communications System (NCS) is the lead agency for communications under the FRP. It consists of representatives from 23 federal agencies and operates under the authority of the GSA. The NCS provides communications support to federal, state, and local response efforts and is charged with carrying out the National Telecommunications Support Plan to ensure adequate communications following disasters.

- *Nuclear Regulatory Commission*. The Nuclear Regulatory Commission (NRC) is responsible for the Federal Radiological Emergency Response Plan (FRERP). Its responds to the release of radioactive materials by its licensees.

b. For additional information on these agencies, refer to FM 100-19.

B-4. Operations Outside the United States

a. The DOS is organized to provide—

- Foreign policy advice to the President.

- Nation-to-nation representation throughout the world.

- United States interdepartmental coordination in various nations with whom the US has relations.

- Worldwide information services.

b. Key planners within the DOS include—

- *Secretary of State*. He is the principal foreign policy adviser to the President and is responsible for the overall direction, coordination, and supervision of US foreign relations and for the interdepartmental activities of the US government overseas.

- *Ambassador and United States country team*. The US country team is composed of senior representatives of all in-country US government departments. The ambassador represents the President as Chief of Mission (COM), but takes policy guidance from the Secretary of State through regional bureaus. He is responsible for all US activities within the country to which accredited and interprets US policies and strategies regarding the nation. The composition of the country team varies widely depending on specific US national interests in the country, the desires of the COM, the situation within the country, and the number and level of presence of US agencies. The ambassador's authority does not, however, include the direction of US military forces operating in the field when such forces are under the command of a US area military command. The CINC usually participates as a member of the country team, even though he is not a member of the diplomatic mission and may not be physically located in the country.

- *Political advisor*. A political advisor (POLAD) is a foreign service officer from the DOS. The DOS assigns a POLAD to each combatant commander and may authorize one to the American operational commander during multinational operations. The POLAD is a valuable asset possessing appropriate regional knowledge and language skills who can assist the combatant commander in translating political objectives into military objectives. Further, the POLAD can facilitate cooperation between the primary US political and military actors. The POLAD often has the ability to move freely throughout an AO and work with a wide range of different parties that might not work with US military personnel.

- *Nongovernmental organizations/private volunteer organizations*. The primacy of political considerations in multinational operations demands a recognition of the importance of nonmilitary participants. Nongovernmental organizations and PVOs are frequently on the scene before military forces and are willing to operate in high-risk areas. They will most likely remain long after military forces have departed. The sheer number of lives they affect and resources they provide enables the NGO and PVO community to wield a great deal of power. Because of their capability to respond quickly and effectively to crisis, NGOs and PVOs can lessen the CMO resources that a commander would otherwise have to devote to an operation. Examples of such organizations include—

    - International Society of the Red Cross and Red Crescent.
    - United Nations High Commissioner for Refugees.
    - Medecine Sans Frontieres.
    - Others.

B-5. Military Effort

As mentioned in paragraph B-2, the military may not be the lead player in interagency operations.

- In OCONUS operations, the Office of the Secretary of Defense and the joint staff coordinate interagency operations at the strategic level. This coordination establishes the framework for coordination by commanders at the operational and tactical levels.

- The combatant commander is the central point for plans and implementing theater and regional strategies that require interagency coordination. The combatant commander may establish an advisory committee to link his theater strategy to national policy goals and objectives of DOS and concerned ambassadors. Military personnel may coordinate with other US government agencies while operating directly under the ambassador's authority, while working for a SAO, or while assigned to a regional combatant commander.

- Coordination among DOD and other US government agencies may occur in a country team or within a combatant command. Military personnel working in interagency operations must ensure that the ambassador and the combatant commander know and approve of all programs. Legitimizing authorities determine specific command relationships for each operation.

B-6. Combat Health Support Implications in Interagency Operations

Depending upon the type of operation (such as disaster relief, domestic support, or nation assistance), the type and scope of CHS will vary. This support is based on the unique requirements for the operation, the desired end state, and the duration of the operation. The delivery of health care, health education, or advice and consultation by military CHS personnel will usually play a supporting role in the overall operation rather than a primary one. The CHS commander must ensure that—

- Legal guidance throughout the operation is obtained to ensure that he adheres to any legal restrictions on the use of military personnel, materiel, and funds.

- A determination as to who is eligible for care by military health care professionals or in military MTFs is made and correctly implemented.

- Credentialing, scope of practice, and malpractice liability requirements are established and enforced for nonmilitary medical professionals operating within a US military MTF or sponsored program.

- Combat health support planners have a complete understanding of the capabilities available from other agencies involved in the operation. (Comprehensive planning will ensure that a duplication of services between agencies is avoided, that the use of scarce resources is maximized, and that the cost of the operation is contained. The CHS planner must also document sources for the reimbursement of expenses [resources expended] [personnel and materiel], where applicable.)

- The CHS contingent receives or develops SOPs that describe its functions, responsibilities, and procedures for each CHS functional area. This ensures the efficient and effective delivery of health care by delineating responsibilities, identifying sources of support, and minimizing confusion in the implementation of support.

- Preventive medicine assets are available to ensure adequate field sanitation and food hygiene measures are taken in US troop areas when housing and food support is provided for by non-US governmental agencies.

- Veterinary assets are available to ensure food wholesomeness and quality when food procurement and support are provided by non-US governmental agencies.

APPENDIX C

RISK ASSESSMENT

C-1. General

Risk assessment is the thought process of making operations safer without compromising the mission. Commanders must continually perform a risk assessment of the conditions under which they operate to prevent the unnecessary loss of personnel or equipment and the degradation of mission success.

C-2. Risk Assessment

a. Risk assessment is a five-step approach for ensuring that operations and mission accomplishment are not compromised by accidents.

b. The five steps of risk assessment are—

(1) *Identify hazards*. Identify the most probable hazards for the mission. Hazards are conditions with the potential of causing injury to personnel, damage to equipment, loss of material, or lessening the ability to perform a task or mission. The most probable hazards are those created by readiness shortcomings in the operational environment. When a list of frequently recurring hazards is applied to a specified task or mission, the most probable hazards can be identified.

(2) *Assess hazards*. Once the most probable hazards are identified, analyze each to determine the probability of its causing an accident and the probable effect of the accident. Also identify control options to eliminate or reduce the hazard. A tool to use in this assessment is the Army standard risk assessment matrix (Figure C-1). A discussion of the factors used in the Army standard risk assessment matrix is contained in Table C-1.

(3) *Make risk decisions*. Weigh the risk against the benefits of performing the operation. Accept no unnecessary risks and make any residual risk decisions at the proper level of command.

(4) *Implement controls*. Integrate specific controls into plans, orders, tactical standing operating procedures (TSOPs), and rehearsals. Communicate controls down to the individual soldier.

(5) *Supervise*. Determine the effectiveness of controls in reducing the probability and effect of identified hazards. Ensure that risk control measures are performing as expected. Include follow-up reviews during and after actions to ensure all went according to plan, reevaluating or adjusting the plan as required, and developing lessons learned.

C-3. Rules of Risk Assessment

The rules which guide the risk assessment process are—

a. Integrate risk assessment into planning.

		HAZARD PROBABILITY				
		FREQUENT A	LIKELY B	OCCASIONAL C	SELDOM D	UNLIKELY E
EFFECT	CATASTROPHIC I	EXTREMELY HIGH		HIGH		MEDIUM
	CRITICAL II		HIGH		MEDIUM	
	MODERATE III	HIGH	MEDIUM			
	NEGLIGIBLE IV	MEDIUM	LOW			

Figure C-1. Army standard risk assessment matrix.

b. Accept no unnecessary risks.

c. Make risk decisions at the proper level.

d. Accept risk if benefits outweigh the cost.

C-4. Three-Tier Approach

The Army has established a three-tier approach to risk assessment.

a. The foundation tier is command level. This level is responsible for a safety plan, setting standards, training consistent with abilities of those being trained, providing resources, and making risk acceptance decisions.

b. The leader level is next. The leader places emphasis on adherence to standards, assesses and balances risks, and is the implementor of the safety controls to eliminate or control risks. Further, he teaches the individual soldier his responsibilities within the risk assessment process.

c. The individual level is last. The individual soldier must understand safety responsibilities, recognize unsafe conditions and acts, and perform to standard.

Table C-1. Factors Used in the Army Standard Risk Assessment Matrix

EFFECT
I. **CATASTROPHIC:** DEATH OR PERMANENT AND TOTAL DISABILITY, SYSTEM LOSS, MAJOR PROPERTY DAMAGE.
II. **CRITICAL:** PERMANENT PARTIAL DISABILITY, TEMPORARY TOTAL DISABILITY IN EXCESS OF 3 MONTHS, MAJOR SYSTEM DAMAGE, SIGNIFICANT PROPERTY DAMAGE.
III. **MODERATE:** MINOR INJURY, LOST WORKDAY ACCIDENT, COMPENSABLE INJURY/ILLNESS, MINOR SYSTEM DAMAGE, MINOR PROPERTY DAMAGE.
IV. **NEGLIGIBLE:** FIRST AID OR MINOR SUPPORTIVE MEDICAL TREATMENT, MINOR SYSTEM IMPAIRMENT.
PROBABILITY
A. **FREQUENT:** INDIVIDUAL SOLDIER/ITEM OCCURS OFTEN IN CAREER/EQUIPMENT SERVICE LIFE. ALL SOLDIERS EXPOSED OR CONTINUOUSLY EXPERIENCED.
B. **LIKELY:** INDIVIDUAL SOLDIER/ITEM OCCURS SEVERAL TIMES IN CAREER/EQUIPMENT SERVICE LIFE. ALL SOLDIERS EXPOSED OR OCCURS FREQUENTLY.
C. **OCCASIONAL:** INDIVIDUAL SOLDIER/ITEM OCCURS SOMETIME IN CAREER/EQUIPMENT SERVICE LIFE. ALL SOLDIERS EXPOSED OR OCCURS SPORADICALLY OR SEVERAL TIMES IN INVENTORY SERVICE LIFE.
D. **SELDOM:** INDIVIDUAL SOLDIER/ITEM POSSIBLE TO OCCUR IN CAREER/EQUIPMENT SERVICE LIFE.
E. **UNLIKELY:** INDIVIDUAL SOLDIER/ITEM CAN ASSUME WILL NOT OCCUR IN CAREER/EQUIPMENT SERVICE LIFE. ALL SOLDIERS EXPOSED, OR POSSIBLY BUT IMPROBABLY EXPOSED; OCCURS VERY RARELY.
NOTE: UNIT EXPERIENCE AND EXPOSURE AFFECT PROBABILITY OF OCCURRENCE.
RISK LEVELS
EXTREMELY HIGH RISK: LOSS OF ABILITY TO ACCOMPLISH MISSION.
HIGH RISK: SIGNIFICANTLY DEGRADES MISSION CAPABILITIES IN TERMS OF REQUIRED MISSION STANDARDS.
MEDIUM RISK: DEGRADES MISSION CAPABILITIES IN TERMS OF REQUIRED MISSION STANDARDS.
LOW RISK: LITTLE OR NO IMPACT ON ACCOMPLISHMENT OF MISSION.

C-5. Levels of Risk

There are four levels of risk. These levels are—

a. Low Risk. Low risk operations are where normal caution, supervision, and safety procedures ensure a successful and safe mission.

b. Medium Risk. There is the probable occurrence of minor, nonlife-threatening personnel injuries and equipment damage in medium risk operations. These operations have a remote possibility that severe injury or death will occur. These operations require complete unit involvement.

c. High Risk. In high risk, mission capabilities are significantly degraded and there is a probability that severe personnel injuries, death, and major equipment damage will occur.

d. Extremely High Risk. In this level, the unit will be unable to accomplish its mission and there is the probability that mass casualties or deaths will occur, plus the complete destruction of equipment.

C-6. Factors to Consider in Risk Assessment

Some factors that might be considered in the risk assessment process are presented in this paragraph. This is not a complete listing of all factors that should be considered, but rather some of the more routine categories. Factors for each mission will be dependent to some respect on the actual mission and where it is to be executed.

a. Level of Activity. This can include both individual and unit activity. With regard to the individual, it can include the type of activity (such as heavy, physical labor or sedentary desk work) or the pace required (such as continuous work with few, if any, breaks). With regard to the level of unit activity, it can include the tempo of the operation (such as a mass casualty situation or the slower pace of running daily sick call) or the phase of the operation (such as setting up or disestablishing the unit area, reinforcing hasty defensive positions, or the unit standing down).

b. Inherent Dangers of Equipment Used. Inherent dangers of the equipment used by the unit can include the potential for accidents if the equipment is used improperly or if it is not working correctly. In medical units if the medical equipment is not correctly calibrated or is otherwise malfunctioning, it presents a danger not only to the operator but also to the patient (such as an improperly calibrated x-ray machine). Further, in the unit there is an abundance of medical and nonmedical equipment which could cause fires or explosions, resulting in collateral damage to personnel or equipment if the equipment malfunctioned.

c. Hazardous Materials Used or Produced. In medical units, there are numerous hazardous materials that are used to perform unit functions or are produced as a by-product of the mission (medical waste). Units must ensure that hazardous materials are properly handled and disposed of to ensure that they do not create a hazard for medical personnel, patients, and the environment.

d. Environmental Concerns. Environmental concerns encompass a number of areas which must be considered by a medical unit. Extremes in temperature can cause heat/cold injuries to medical personnel and increase the patient work load. Commanders must ensure that areas occupied by soldiers/units are free from industrial contamination, such as that found around chemical plants, petroleum storage areas, or iron foundries. Terrestrial elevations upon which operations are conducted can lead to mountain illness and increased numbers of impact injuries. Commanders must also consider the effect of the mission on the environment. Such effects can cause an imbalance in the ecosystem, which may lead to unhealthy conditions for soldiers and for indigenous and refugee populations. (Refer to Training Circular 5-400 for information on evaluating environmental risks.)

e. Availability of Protective Equipment. This factor includes items common to all military units (such as fire extinguishers, MOPP gear, or ear plugs) as well as items that are primarily found in medical units

(such as patient protective wraps and items used for universal protective measures). Medical units must consider the equipment available to the unit members as well as that required for the patients in their care.

f. Accident Frequency. The commander should focus on what types of accidents occur in the unit, their frequency, and areas in which they occur. If the frequency of accidents increases or if the accidents continue to occur in one operational area, it may be necessary to tighten control measures in these specific areas while instituting more generalized measures throughout the other operational areas.

g. Supervision. Supervision can serve as a control measure in areas where the frequency of accidents and/or other indications of hazards exist. The lack of supervision or inadequate supervision can result in an increase of hazards and accidents. The commander is challenged by the need to balance supervision to decrease hazards, but not stifle productivity.

h. Weather. Weather conditions can increase the hazards of accomplishing the CHS mission as they can make it difficult to accomplish tasks and increase the risk associated with operating equipment/ vehicles/aircraft. For example: Weather which impacts adversely on the use of air ambulances results in increasing the patient load and the number of missions that are accomplished by ground ambulance. Adverse weather may also result in a BAS or clearing station having to hold patients longer than is normally required. This can result in overcrowding the facility and rapidly depleting the stocks of medical supplies during a time when resupply may be difficult or impossible to accomplish.

i. Operational Conditions. These will vary with each mission. Units operating in remote locations or in underdeveloped areas have a higher potential of exposure to endemic and epidemic diseases (medical threat). Unimproved roads, rudimentary sanitation, and difficult terrain coupled with extremes in weather can create hazards not previously experienced in operational conditions.

j. Condition of Personnel. Soldiers who are well conditioned physically, acclimated to the climate in the operational area, and well trained and motivated perform tasks to a higher standard than do soldiers who are not. Continuous operations which restrict the amount of rest soldiers receive, strenuous activity in soldiers who are not acclimated to the climate, untrained and unmotivated soldiers, and those who are not physically well conditioned are some factors which can result in—

- More frequently occurring accidents.
- Job performance standards not being met.
- Preventive maintenance not being accomplished on unit equipment.

k. Personnel/Organizational Proficiency. Combat health support personnel are normally well trained within their medical specialties due to the length of training and the standards required to be met for award of their specialties. Many CHS personnel, however, are not as familiar with field duties as they are with those performed in TDA facilities. The commander must assess how familiar his soldiers are with the field medical equipment contained in their MESs and with the common soldier tasks they are required to perform in the field.

l. Adequacy of Site. The CHS commander must carefully evaluate the area assigned for the establishment of the MTF. Sufficient real estate must be allotted for establishing the MTF, providing an ambulance turnaround point, establishing a helicopter landing area, permitting augmentation of the medical assets, providing a patient decontamination area, and permitting the establishment of administrative areas and sleep areas. Trying to establish an MTF in too restrictive of an area can increase traffic jams, resulting in accidents and injuries to personnel, not permitting the safe location of hazardous equipment within the unit area, and disrupting the patient flow within the facility, which can degrade the care rendered to patients.

m. Level of Planning. Planning is the key to mission success and the safe operation of the unit. Planning includes more than the planning required to support the tactical plan. Every phase of the operation requires detailed and continuous planning to ensure that deployment, mission execution, and redeployment are accomplished in the most efficient and safe manner possible. For example, if the unit field sanitation plan is not developed and executed, combat ineffectiveness can result from the spread of disease and contamination.

n. Complexity of Movement. When a unit is deploying or redeploying, a number of transportation means may be used to accomplish the move (such as by rail to a port of embarkation, by ship to the port of debarkation, or by convoy from the port of debarkation to the operational area). Each of these modes of transportation have special requirements to ensure that the personnel, vehicles, and equipment are safely transported from one point to another. The commander must evaluate the plan for the move, assess the hazards it presents, and institute controls to ensure the move is accomplished in a safe manner. This same planning and hazard assessment is required for moves of much smaller scope such as when an Echelon II unit deploys a treatment team forward to augment an Echelon I BAS using organic vehicles.

o. Adequacy of Directions Given. Leaders must always ensure that the directions they give are clear and complete and that the soldiers receiving the directions understand what they are expected to do. Accidents, substandard job performance, and mission failure can result if the personnel performing the tasks do not understand what they are to do, when they are to do it, and how they are to do it.

APPENDIX D

MULTINATIONAL OPERATIONS

D-1. General

Multinational operations are those military actions that encompass two or more countries. These operations serve two purposes. First is the simple combination of numbers. Countries associate themselves in military operations to bring their separate military forces together into a more powerful combined force. Increasingly, however, multinational operations serve a political purpose. The combined efforts of two or more countries lend legitimacy to the enterprise, demonstrating broad international approval of the operation. For example, in the Persian Gulf War of 1991 (Operation Desert Storm), even token military contributions by small countries added their moral and political backing to the international effort to force Iraq out of Kuwait.

D-2. Alliances and Coalitions

There are two types of multinational forces: alliances and coalitions. These forces must create a structure that meets the needs, diplomatic realities, constraints, and objectives of the participating nations.

a. Alliances. Alliances are long-standing agreements between or among nations for the attainment of broad, long-term objectives. An example of an alliance is the North Atlantic Treaty Organization (NATO).

b. Coalitions. Coalitions, on the other hand, are *ad hoc* agreements between two or more nations for a common action (the attainment of a short-term objective).

D-3. Command Structure of Multinational Forces

a. Alliances.

(1) Alliances are characterized by years of cooperation among nations. In alliances—

- Agreed-upon objectives exist.
- Standard operating procedures have been established.
- Appropriate plans have been developed and exercised among the participants.
- A developed TO exists, some equipment interoperability exists, and command relationships have been firmly established.

(2) Alliances are normally organized under an integrated command structure that provides unity of command in a multinational setting. The key ingredients in an integrated alliance command are that a single commander will be designated, that his staff will be composed of representatives from all member

nations, and that subordinate commands and staffs will be integrated to the lowest echelon necessary to accomplish the mission. Figure D-1 depicts a multinational alliance under an integrated command structure.

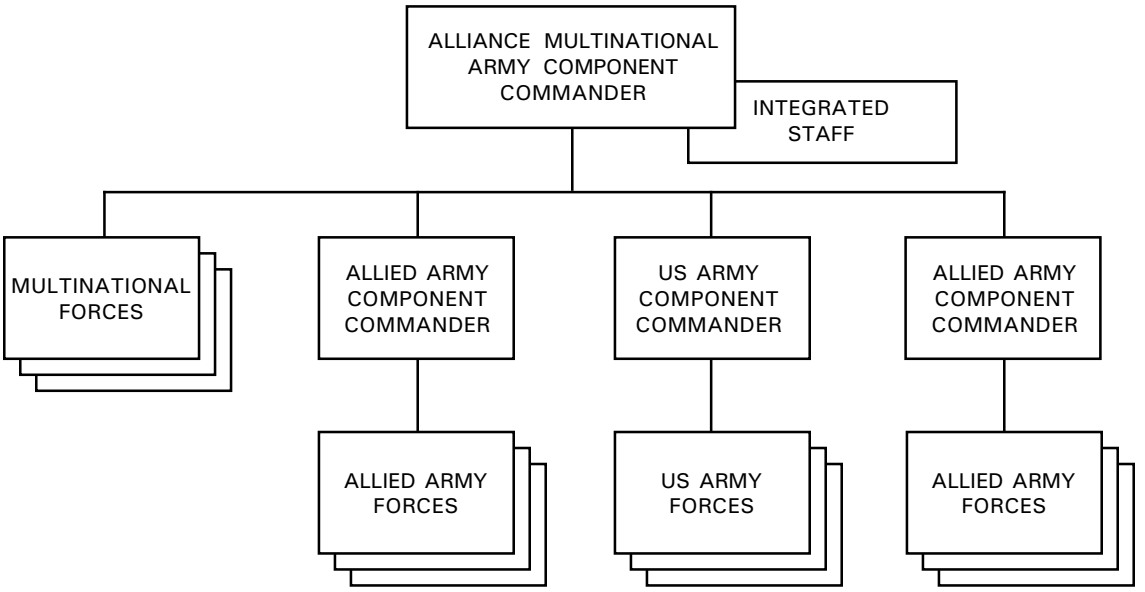


Figure D-1. Multinational army command structure alliance (national subordinate formations).

(3) Another form of alliance is the lead nation command structure. This structure may exist in a developing alliance when all member nations place their forces under the control of one nation. This means that the lead nation's procedures and doctrine form the basis for planning and coordinating the conduct of operations. Although this type of arrangement is unusual in a formal alliance, such a command structure may have advantages under certain treaty circumstances. A lead nation command in an alliance may be characterized by a staff that is integrated to the degree necessary to ensure cooperation among multinational or national subordinate army formations.

b. Coalitions. Coalitions are normally formed as a rapid response to an unforeseen crises and, as stated above, are *ad hoc* arrangements between two or more nations for a common action.

(1) During the early stages of such a contingency, nations rely upon their military command systems to control the activities of their forces. Therefore, the initial coalition arrangement will most likely involve a parallel command structure (Figure D-2). Under a parallel command, no single multinational army commander is designated. Usually member nations retain control of their national forces. Coalition decisions are made through a coordinated effort among the participants. A coalition coordination, communications, and integration center (C3IC) can be established to—

- Facilitate exchange of intelligence and operational information.

- Ensure coordination of operations among coalition forces.
- Provide a forum for resolving routine issues among staff sections.

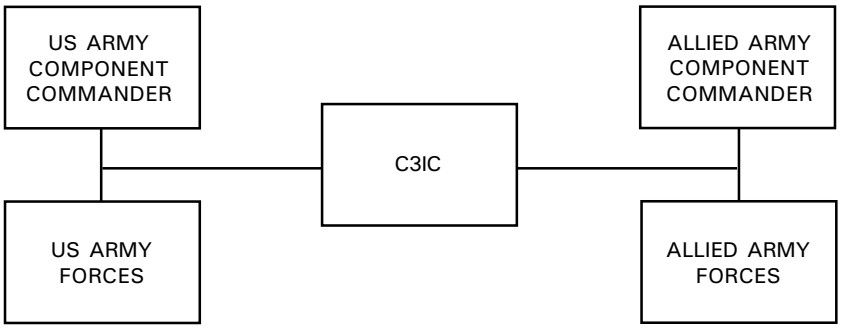


Figure D-2. Coalition parallel command structure (forces under national control).

(2) As a coalition matures, the members may choose to centralize their efforts through establishing a lead nation command structure (Figure D-3). A lead nation command is one of the less common command structures in an *ad hoc* coalition. A coalition of this makeup sees all coalition members subordinating their forces to a single partner, usually the nation providing the preponderance of forces and resources. Still, subordinate national commands maintain national integrity. The lead nation command establishes integrated staff sections, with the composition determined by the coalition leadership.

D-4. Rationalization, Standardization, and Interoperability

One of the most difficult aspects of multinational operations concerns the rationalization, standardization, and interoperability (individually defined in the Glossary) of equipment, supplies, and procedures. This task is compounded by differences in terminology, language, and doctrine.

a. Communications. To ensure mission success, it is imperative that communications are quickly established with all participating nations.

(1) Initial communications can be facilitated by exchanging liaison teams who will provide direct interface with the participating nations. When possible, liaison personnel should be deployed early in the planning/organization phase of the operation.

(2) Compatible communications equipment may pose a severe problem for the multinational force. Even within joint operations, the US experiences interoperability problems with communications

equipment; these difficulties are magnified when US forces are engaged in multinational operations. Depending upon the size of the multinational force, one nation may be required to provide communications equipment to all elements for C2 purposes. The planning for and effective use of messengers and wire communications may also assist in alleviating this situation.

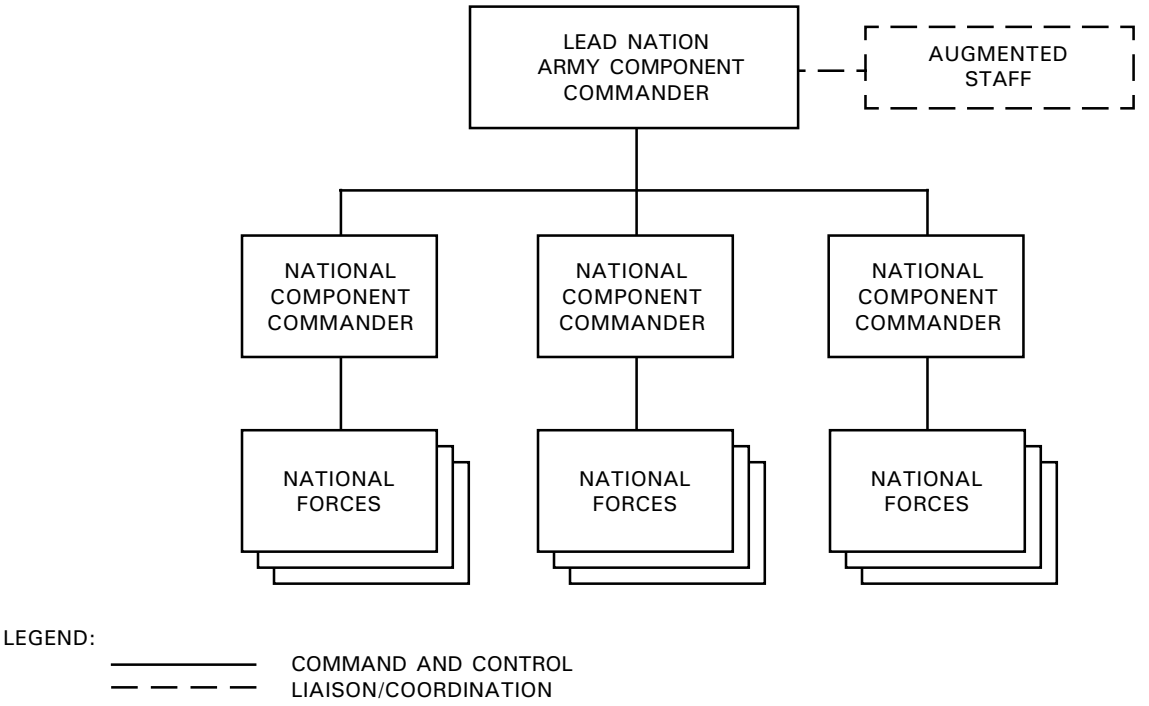


Figure D-3. Lead nation command structure (augmented staff and multinational subordinate formations).

b. Standardization. Within alliances, standardization can be accomplished in many areas. The specifications and requirements for equipment, treatment protocols, and procedures can be developed by working groups and adopted for use by each nation. An example of this is the NATO standard litter which can be interchangeably used in all ambulances employed by the member nations. In coalitions there is not sufficient time permitted to reach standardization agreements of this nature. Due to the short duration and limited purpose of these arrangements, there is usually only sufficient time to standardize principles and time-sensitive procedures, such as report formats or radio frequencies to be used, rather than materiel development issues.

c. Command and Control. As coalitions are *ad hoc* agreements of countries sharing a common interest, it may not be possible to establish C2 over all participants as each nation may have its own specific requirements which limit the authority it will permit international or national commanders to exercise over

its forces. Thus, command in the formal sense may not exist, and a system of cooperation may be required in its place. Hasty agreements must be made to formulate workable methods. These are always specific to the situation and must be decided by commanders and staffs, taking into consideration the mission, requirements, and capabilities of the participating forces.

D-5. Combat Health Support Issues

The US military has a sophisticated, state-of-the-art field health care delivery system. When engaged in multinational operations, the US may be called upon to provide health care to the forces of allied or coalition partners engaged in the ongoing operation. Factors which may impact on the delivery of this care include—

a. Eligible Beneficiaries. Early in the CHS planning process, a determination must be made as to who will be eligible beneficiaries for care in US MTFs. This determination should be made at the highest possible level with the advice of the Staff Judge Advocate as it will impact on the medical force structure to be deployed and the expenditure of funds on Class VIII materiel required to support the eligible population.

b. Funding. The funding and/or reimbursement aspects of the operation should be clearly delineated at the outset of the operation. Multinational operations are often conducted under the auspices of nongovernmental agencies, such as the UN. The CHS planner must know what the mechanisms for reimbursement are and what methods of resupply are to be used.

c. Differences in Languages. Interpreters will be required to assist medical personnel in treating soldiers from other nations who do not speak English. Department of the Army Pamphlet 40-3 provides basic medical questions and responses in the languages of the NATO members, but must be supplemented by locally produced guides for languages not included.

d. Endemic Disease. When treating soldiers from other nations, the health care provider must be familiar with the endemic diseases in the soldier's native homeland. These diseases may or may not be endemic in the AO. Treating soldiers with varying endemic diseases may require medications not normally stocked by the treatment element. As these diseases may not be familiar to the health care providers, additional consultation with specialists may be required.

e. Religious and Cultural Differences. Religious and cultural differences will exist between the different forces. Health care providers must be aware of any cultural norms or religious beliefs which affect the delivery of health care. These differences may be encountered in areas such as the use of blood and blood products or dietary restrictions. By the health care provider being aware of and considering these cultural differences and religious beliefs, cooperation of the patient for the treatment regime may be facilitated.

f. Nuclear, Biological, and Chemical Threat. Each nation will have different methods and materiels for safeguarding their troops from the effects of NBC weaponry. This may result in different levels of protection for the various forces participating in the operation. The CHS planner must consider the various levels of protection to ensure that adequate health care support can be provided in the event that NBC weaponry is employed.

D-6. Combat Health Support Considerations

The command surgeon will be required to establish policies and procedures which will affect the type and quantity of CHS available to the participating forces. As a minimum, the following factors should be considered—

a. Patient Evacuation and Medical Regulating.

- The evacuation policy for the theater/operation must be established during the initial planning phase because much of the medical force structure to be deployed is dependent upon this policy.

- It must be established who will perform medical evacuation missions and what assets (platforms and personnel) will be used. (Is one nation the primary evacuator or will each nation evacuate their own patients?)

- It must further be determined where patients from the different member nations will be evacuated to (such as to the nearest facility regardless of nationality or to a facility established by their own nation).

- The communications interface (type of radio, frequency, and request format) must be standardized to facilitate the receipt of the request and expedite the dispatch of the evacuation platform.

- Additional policies may be required on the exchange of litters, blankets, and other types of medical equipment accompanying the patient, on the backhaul of Class VIII and blood on ambulances, and on transferring a patient from one nation's evacuation system to another.

b. Hospitalization. The array of hospital assets within a TO or deployed for an operation is dependent upon the nature and duration of the operation, the anticipated patient work load, and the theater evacuation policy. In multinational operations, it needs to be determined which nations will provide hospitalization and, once that is established, what capabilities these assets have. Standards of medical care, credentialing, scope of practice, and ancillary care available will differ between participating nations. A clear understanding of the medical capabilities of each nation's facilities is an essential requirement for the CHS planner to ensure that a duplication of services does not occur and that all elements of care are provided for. Further, the participating nations must establish at what point a patient within the health care delivery system of one nation will be returned to his own nation's system.

c. Combat Health Logistics. Different nations have different standards for collecting and testing blood as well as for the production of pharmaceuticals and medical equipment. Due to the stringent regulation of blood and blood products and the production of pharmaceuticals in the US, these Class VIII items will normally only be procured through the US forces Class VIII system for use with US troops. Funding and reimbursement mechanisms must be identified and formalized if the US Class VIII system is used to resupply other nations' MTFs.

d. Preventive Medicine Services. Preventive medicine programs are essential in reducing morbidity and mortality due to DNBI. In a multinational force, the PVNTMED personnel must be familiar

with the cultural and religious differences of the participating nations. Field sanitation and personal hygiene practices are not universally the same in all nations; in some nations, these practices do not exist. To ensure that endemic diseases of a particular nation are not introduced to the other participating forces, disease surveillance, pest management, and personal protective measure programs must be initiated and enforced. Inspection of bivouac areas, feeding facilities, potable water supplies, and waste disposal and sanitation facilities must be an ongoing effort. In addition, ensuring that operations are in compliance with federal, state, local, and HN environmental laws, regulations, policies, and standards will help to prevent an imbalance from occurring in the ecosystem. Such an imbalance occurring in the ecosystem should be avoided because it could make human health and disease conditions worsen.

e. Dental Services. Dental services within the multinational force may be the responsibility of each participating nation. If care is to be provided by one nation, it would normally only consist of emergency dental procedures to provide for the immediate relief of pain and discomfort.

f. Area Medical Support. A comprehensive plan must be established to ensure that all participants have access to medical care and services. Whether one nation provides all of the essential services or each nation is responsible for its own care (or some combination of the two), a comprehensive plan which delineates the access to and interconnectivity of support must be provided. Units or elements without organic CHS resources must receive Echelons I and II support on an area support basis and these support requirements must be incorporated into the supporting units' OPLAN.

g. Veterinary Services. The AMEDD is the DOD Executive Agent for Veterinary Services within the US Army. Its missions of ensuring food wholesomeness and quality and providing medical care to government-owned animals are an essential service in stability and support operations. The US forces may have the only deployable veterinary resources and may be required to perform their missions for the entire multinational force.

APPENDIX E

COMBAT HEALTH SUPPORT ASSESSMENT CHECKLIST

E-1. General

a. This appendix provides a tool for use in assessing the health care delivery system and the medical needs of a HN or US-backed group. This checklist is intended only as a guide and may be modified for use as the situation dictates.

b. This checklist is arranged by category of information. The more detailed the information obtained, the better this checklist will aid the CHS planner in correctly identifying the medical threat, assessing the medical requirements, and developing the requisite programs for alleviating the identified deficiencies. Additional information in the form of brochures, magazine or newspaper articles, or advertisements of medical facilities, health service education programs, and medical equipment or supplies available will also assist in the planning effort.

c. The mission reconnaissance checklist presented in Appendix M is more limited in scope and is intended for the assessment of a specific village, town, or district.

d. Predeployment medical assessments may be available through supporting CA units.

E-2. Sample Medical Assessment Checklist

COUNTRY _____ DATES VISITED _____ TO _____

I. GENERAL INFORMATION

Name of Location _____

Map Grid Coordinates _____

Topography (such as mountains or desert) _____

Climate (such as tropic or arctic) _____

Temperature Ranges:

Summer _____ to _____

Winter _____ to _____

Significant Seasonal Variants (such as monsoon season) _____

Availability of Water

Source	Quality	Quantity	Contaminants

Epidemiology

Disease	Occurrence

Leading Cause of Death

Status of Sanitation Impacting on the Overall Health

Insects, Plants, and Animals of Medical Importance

Religious, Social, and/or Political Factors of Medical Importance

II. CIVILIAN HEALTH SERVICES

Organization and Administration (to include public and private)

Public Health Laws

Accessibility to Care (to include both physical, social, and financial barriers)

Comments on Overall Quality of Civilian Health Care

Significant Individuals

Name	Title

III. MILITARY MEDICAL SERVICES

Force Strength

Active _____ Reserve _____

Organization and Administration

Policies and Programs

Physical Fitness Standards

Medical Logistics and blood Management

Medical Evacuation and Regulating

Hospitalization

Preventive Medicine

Dental

Veterinary

Pharmacy, Laboratory, and X-ray

Combat Stress/Neuropsychiatric

Nursing

Paraprofessionals

Military Medical Training and Education Programs

Course/School	Location	Type of Training

Comments on the Overall Quality of Military Care

Significant Individuals

Name	Title

IV. MEDICAL MATERIEL

Production Capability

Product	Quantity	Demand

Stockpiles

Product	Quantity	Demand

Products Obtained from Outside Sources

Product	Quantity	Demand

Equipment Repair Capability

Type of Equipment	Source of Repair

V. MEDICAL RESEARCH AND DEVELOPMENT

Institutes

Name	Location

Significant Individuals

Name	Title

VI. CIVILIAN MEDICAL TRAINING

Course/School	Location	Type of Training

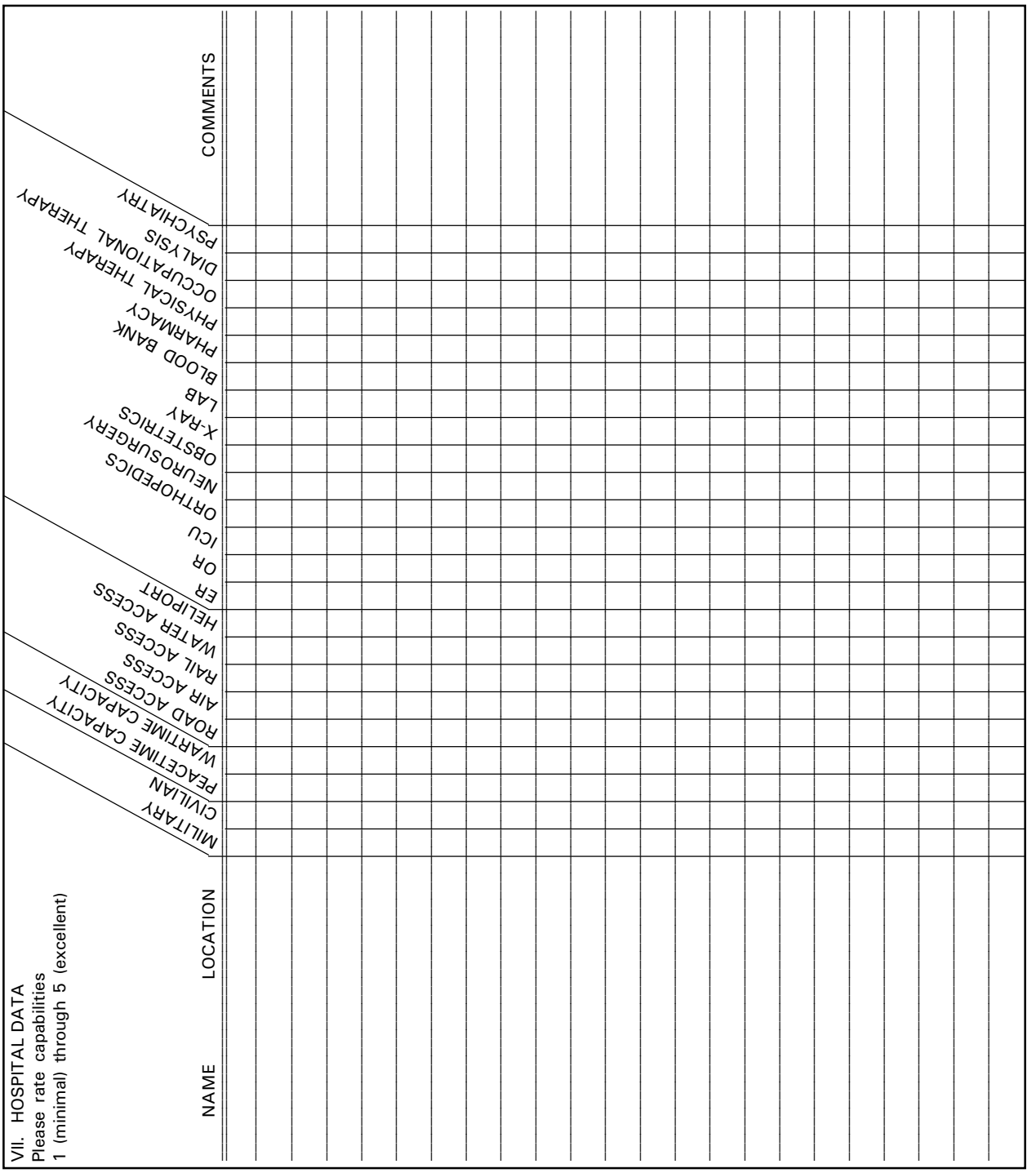
Other Comments

_____

_____

_____

_____


VII. HOSPITAL DATA
Please rate capabilities
1 (minimal) through 5 (excellent)
NAME
LOCATION
MILITARY
CIVILIAN
PEACETIME CAPACITY
WARTIME CAPACITY
ROAD ACCESS
AIR ACCESS
RAIL ACCESS
WATER ACCESS
HELIPORT
ER
OR
ICU
ORTHOPEDICS
NEUROSURGERY
OBSTETRICS
X-RAY
LAB
BLOOD BANK
PHARMACY
PHYSICAL THERAPY
OCCUPATIONAL THERAPY
DIALYSIS
PSYCHIATRY
COMMENTS

APPENDIX F

COMBAT HEALTH SUPPORT ASSESSMENT PLANNING FOR STABILITY OPERATIONS AND SUPPORT OPERATIONS

Section I. COMBAT HEALTH SUPPORT ESTIMATE

F-1. General

a. Planning for CHS operations in stability and support operations is the same process as used for traditional CHS operations. The CHS estimate of the situation is the basic tool used by the CHS planner. A detailed discussion of each subparagraph of the CHS estimate is provided in FM 8-55. The information contained in this appendix supplements the discussion in FM 8-55. The considerations are similar; however, the range of options and COAs are expanded. These expanded options include missions and functions not accomplished during the more traditional CHS operations (such as the assessment of the HN medical infrastructure).

b. All of the categories of the CHS estimate are presented in paragraph F-2. Some of the categories may seem contrived when applying them to a stability and support operational situation. The CHS planner must, therefore, interpret the categories and apply the pertinent information or modify the category to fit the operational scenario. In some stability and support operational scenarios, there may not be a recognizable enemy; the *enemy* and *friendly* situation paragraphs of the estimate can be thought of as *negative* and *positive* factors impacting on the successful accomplishment of the mission. For example, in a discussion of opposition groups, it is conceivable that an organized opposition may not be apparent in a country where a humanitarian assistance program or disaster relief effort is being conducted. The CHS planner should, therefore, consider those situations and factors which could foster an insurgency or the formation of opposition groups and focus the CHS operations to correct anticipated deficiencies, thereby eliminating the possible threat.

c. Paragraphs F-3 through F-7 contain a format for preparing the veterinary, PVNTMED, dental, CSC, and CHL estimates.

d. The examples provided in this section do not include all possible scenarios or information needed to complete an estimate. They are intended to be thought provoking and are included for illustrative purposes only.

F-2. Sample Format for the Combat Health Support Estimate

(Classification)

Headquarters
Location
Date, time, and zone

COMBAT HEALTH SUPPORT ESTIMATE OF THE SITUATION

References: *List all maps, overlays, charts, or other documents required to understand the plan. Reference to a map will include the map series number and country or geographic area, if required; sheet number and name, if required; edition; and scale.*

1. MISSION (*Statement of the overall CHS mission and type of activity to be supported* [*such as support for insurgency or counterinsurgency, combatting terrorism, peace support or domestic support operations*].)

2. SITUATION AND CONSIDERATIONS

a. Enemy (Opposition) Situation/Negative Factors. (*In stability and support operations, this can include terrorist groups, insurgents, renegade forces, or other opposition groups or political factions found in the particular country. This subparagraph is viewed as groups opposed to the US-backed and supported groups, HN, and US national interests. In disaster relief or domestic support operations where there is no recognizable enemy, this could include looters or other lawlessness, continued danger from recurring earthquakes, storms, or floods, or an increased medical threat due to disruption of sanitation and services.*)

(1) Strength and disposition. (*Included in this category are strongholds, areas sympathetic to the opposition group, or the size and type of organization of the opposition group.*)

(2) Combat efficiency. (*Information on actual combat units or guerrilla forces, their training status, and their level of experience and expertise can be identified here. The level of their medical training and their health care delivery system can also be discussed.*)

(3) Capabilities. (*Information on the actual capabilities of an opposition group to wage armed combat or the potential of the group to initiate such action is included. Consideration should be given to the possibility of an opposition force being able to employ NBC and DE weaponry/devices.*)

(4) Logistics situation. (*This can include information on how well supplied the opposition force is with food, clothing, or other vital logistics factors. The financial backing and availability of future support from outside individuals* [*such as from narcotics traffickers*] *or other countries can also be included.*)

(Classification)

(Classification)

(5) State of health. (*Medical resources available to the opposition group and their location or the general health status of this subpopulation should be considered.*)

(6) Weapons. (*This includes the types and quantities of weapons; amount of ammunition; availability of NBC and DE weapons/devices; sources and outside backing for obtaining weapons; and the potential for improving the state of the arsenal.*)

b. Friendly Situation/Positive Factors. (*This subparagraph is addressed from the perspective of the HN or US-backed group and US national interests. In domestic support or disaster relief operations it could include a number of volunteers, experienced search and rescue teams, and donated supplies.*)

(1) Strength and disposition. (*This could include information on the Armed Forces, guerrilla forces, strongholds, sympathetic areas, and support of the general populace.*)

(2) Combat efficiency. (*This includes the state of military and medical professional training and experience of the HN military or US-backed group; status of the development of a professional medical corps* [*including administrative, ancillary and rehabilitative care, nursing, dental, and veterinary specialties*]*; training in first aid* [*self-aid, buddy aid, and combat lifesaver skills*] *within the fighting forces; existence of formal TOE-type units; level of personal hygiene and field sanitation; development of the military and health care infrastructure; and CS and CSS resources available to the force.*)

(3) Present and projected missions. (*This includes HN restrictions and limitations on the scope and objective of the mission, the visibility of the HN to its population in implementing the programs, and the capability of the HN to continue the programs once US assistance is withdrawn.*)

(4) Logistics situation. (*This includes both the medical and nonmedical logistics situation. Information on the status of food, clothing, or other vital logistics factors affecting the friendly forces should be included. Location of resupply points or activities, coordination for depot maintenance, and procedures for supply or resupply if the support facility is not located in the AO should be included. If the HN is not supplying the logistics support, an indication of the sources of support and the potential for continuance of support should be included. This should also include any available CHS resources from allied or coalition forces, NGOs, and PVOs.*)

(5) Rear battle plan. (*This includes information on antiterrorism operations and measures or force protection operations.*)

(6) Weapons. (*This includes those weapons and riot control agents available to the force.*)

c. Characteristics of the Area of Operations. (*Included in this are geographical barriers and political borders.*)

(Classification)

(Classification)

(1) Terrain. (*Special considerations include the effects on limiting the access to and availability of health care services for the general population; regionalization of the population which does not have access to improved roads; effects on camouflaging and protecting insurgents or guerrillas; MOUT considerations and requirements, or potential for earthquakes, volcanic eruptions, or other natural disasters*.)

(2) Weather. (*This includes seasonal weather and the potential for hurricanes/typhoons, tornadoes, or monsoons* [*for example, conditions which may further isolate villages and sections of the population due to flooding, or its adverse effect on a disaster relief mission, or any other significant role it may play in an operation being planned*].)

(3) Civilian population. (*The civilian population takes on added importance in planning missions for the stability and support operational environment. Oftentimes, the civilian population is, in fact, the focus of the mission. A thorough understanding of the culture, language, political, economic, religious, and social situation of the populace involved is a crucial element in planning missions in stability and support operations. If conventional military operations are being undertaken in the area, the effect these operations have on the civilian population must be considered. The requirement for prosthetics, orthotics, and training of alternative daily living activities and skills of civilian victims of land mines or other combat-related traumatic injuries should also be considered. Estimates of collateral injuries to civilians resulting from MOUT and the number of refugees fleeing combat operations and their impact on health care delivery, preventive medicine, and veterinary support should be included. In domestic support and disaster relief operations, the percentage of the population affected, the resources within the civilian community, and eligibility for care factors need to be considered.*)

(4) Flora and fauna. (*As in all military operations, personnel must be familiar with the particular plants, animals, and arthropods which are found in the operational environment. In stability and support operations, this is important, as the resources available to control arthropod and rodent populations may not be available. This results in exposing the deployed forces to a greater incidence of disease and injury. The animal population of the region may play a significant role in the region's economic development, and may, therefore, be the focus of the operation* [*refer to Chapter 4*].)

(5) Local resources. (*In stability and support operational scenarios, the availability of resources in the HN plays a significant role in shaping the CSS requirements of the deployed force. Availability of food, water, hospitalization services, and means of evacuation are only a few of the considerations in planning the CSS for an operation. Coordination needed to affect the HN support in the treatment of civilian casualties resulting from military operations should also be included.*)

(6) Other. (*This includes, but is not limited to, language capabilities and requirements; educational levels of the general population and HN military or US-backed group; state of development of the medical infrastructure for both the HN and the military; morbidity and mortality statistics; primary care capabilities; adequacy of secondary and tertiary hospital facilities; access to the health care delivery system; education and training levels of health care professionals; availability of prosthetic and orthotic devices;*

(Classification)

(Classification)

education and training for rehabilitation programs; adequacy of sanitation facilities; religion; and status of the medical evacuation system. The availability of and access to radios, televisions, and other forms of communications are significant factors in developing training and educational programs focused on the populace.)

d. Strengths to be Supported. (*This section of the estimate should be modified as required to fit the stability and support operational mission. In some operations, such as peacekeeping operations, the type of support provided is mainly of a traditional type, and the supported population can be accurately projected. In other operations, such as the support for insurgency and counterinsurgency, the supported population may not be as easily defined. The requirements to support SOF elements with conventional CHS resources should also be considered. Additionally, in stability and support operations, there will often be either a joint or multinational force involved. Combat health support considerations should, therefore, be thoroughly coordinated to ensure that duplication of services is avoided* [*consideration should also include HN, allied, or coalition forces, interagency, NGOs, or PVOs medical services and programs*]. *Some of the classifications listed below pertain to categories recognized by the Geneva Conventions and may or may not be applicable to the planned operation.*)

(1) Army.

(2) Navy.

(3) Air Force.

(4) Marines.

(5) Allied forces.

(6) Coalition forces.

(7) Enemy prisoners of war/detainees. (*In many stability and support operational scenarios, there will be no EPW; however, there may be some individuals who are considered to be detained, or internment and resettlement operations may be conducted.*)

(8) Indigenous civilians. (*This is an important category and should be predicted as accurately as possible.*)

(9) Retainees. (*Enemy medical personnel are not considered as EPW and should be identified as soon as possible to assist in providing medical care in the EPW compound, if applicable.*)

(10) Internees.

(Classification)

(Classification)

(11) Others. (*This can include DOD civilians and contractors, refugees from areas experiencing violent confrontations or oppression, resulting from insurgency or counterinsurgency operations; refugees from other countries; and members of NGOs and PVOs deemed eligible for support.*)

e. Health of the Command. (*With the limited number of forces employed in stability and support operations and their increased risk of exposure to arthropods, rodents, and endemic diseases, it is important to ensure all PMM are taken.*)

(1) Acclimation of troops. (*Due to short notice deployments, acclimation of troops prior to deployment or initially upon entry into the AO may not be possible. To decrease incidence of climatic injuries, work schedules should be modified to accommodate the acclimation process whenever possible. When work schedule modifications cannot be accomplished, ensure adequate drinking water is available to reduce heat stress.*)

(2) Presence of disease. (*This includes the endemic diseases which are not at a clinically significant level in the native population. Deploying forces may not be immune and the incidence of endemic diseases may increase with the disruption of services* [*such as sanitation and garbage disposal*]. *The status of potable water, water sources, and sanitation facilities in rural areas should be routinely inspected and approved for use.*)

(3) Status of immunizations. (*This category may apply to both the military and civilian populations. The US military forces should receive all appropriate immunizations prior to deployment. The immunization of children against common childhood diseases can have a significant impact on the morbidity and mortality statistics of a nation.*)

(4) Status of nutrition. (*This category may apply to both the military and civilian populations and is a significant consideration when planning humanitarian assistance programs for children and refeeding programs for famine victims; refeeding programs for healthy populations such as victims, relief workers, and care givers in disaster relief; and sustainment feeding programs for insurgents and their families.*)

(5) Clothing and equipment. (*Considerations for specialized clothing and equipment necessary to operate in a particular climate or on a particular type of terrain should be included. Examples of clothing and equipment requirements are mosquito netting, jungle fatigues, winter parkas, skis, or mountain climbing equipment.*)

(6) Fatigue. (*The fatigue factor must be monitored, as fatigue can contribute to lowering the resistance to diseases, stress reactions, and faulty decision making.*)

(7) Morale. (*This is an important consideration when dealing with a HN military or a US-backed group. The availability and quality of medical care if wounded plays a significant role in the morale of a fighting force.*)

(Classification)

(Classification)

(8) Status of training. (*This was mentioned earlier in regard to military and professional training levels of the HN or US-backed groups. It can also be applied to the preparation of the US forces for the accomplishment of their stability and support operational mission* [*instruction in language, customs, or the ability to operate in an advisory or teaching capacity*].)

(9) Other. (*As appropriate.*)

f. Assumptions. (*Assumptions may be required as a basis for initiating the planning process or preparing the estimate. Assumptions are modified when specific planning guidance and factual data become available.*)

g. Special Factors. (*Mention items of special importance in the particular operation to be supported* [*such as the requirement to provide stress management after a terrorist incident to victims, security forces, and care givers*].)

3. ANALYSIS

a. Patient Estimates. (*Indicate rates and numbers by type of unit, if providing traditional CHS. If providing humanitarian assistance, indicate types and numbers of cases to be treated.*)

(1) Number of patients anticipated. (*This entry can apply to the types and numbers of patients expected to be treated on humanitarian assistance projects and disaster relief operations. The CHS planner and medical professionals must determine what type of cases will be accepted. Caution must be exercised to ensure that the operation is directed at providing treatment to those who will benefit the most and avoid overexpenditure of scarce resources to treat exotic or interesting cases. If providing support to US, allied, and coalition forces, endemic disease rates within the separate populations may vary necessitating separate patient estimates for each population.*)

(2) Distribution within an area of operations (space). (*This can include planning for operations to visit isolated villages* [*Appendix M*] *or in a disaster area.*)

(3) Distribution in time during the operation (evacuation time). (*This may include the time factors to reach isolated villages to medically evacuate US personnel from the area for further treatment, or to provide aid during disaster relief operations.*)

(4) Areas of patient density. (*This could include the size of the villages and their relationship to one another; whether establishing a centrally located treatment station would benefit the population of a number of villages; areas under siege or where potential violence is anticipated; pockets of injured in a disaster relief operation; or mass casualties resulting from terrorist actions.*)

(5) Possible mass patients. (*This could include lucrative targets for terrorist acts* [*such as the Marine barracks in Beirut*]*; areas experiencing an epidemic; or locations in a disaster relief operation.*)

(Classification)

(Classification)

(6) Lines of patient drift and evacuation. (*Although this is more fitting for conventional warfare scenarios, refugee evacuations do occur in stability and support operations when insurgents or guerrillas try to establish strongholds within a city or region, or disaster victims try leaving the disaster area.*)

b. Support Requirements.

(1) Evacuation. (*When limited US, allied, or coalition forces CHS elements are deployed in an AO, such as a peacekeeping operation, thorough planning and coordination are required to ensure that adequate medical evacuation resources are available for routine care or mass casualty situations. Consideration must also be given to assessing the medical evacuation system within the HN or the US-backed group and providing suggestions or developmental plans for improving or establishing a formal evacuation system. In domestic support operations, US military evacuation resources may be used in disaster relief or community service operations.*)

(2) Hospitalization. (*In stability and support operational scenarios, hospitalization of US forces may not be possible in the immediate AO. It is, therefore, necessary to ensure that thoroughly coordinated plans with other US forces or commands, allied forces, coalition forces, or the HN are implemented to provide the anticipated hospitalization requirements. In assessing the CHS requirements for the HN, the CHS planner must consider the availability and adequacy of primary care; the adequacy and accessibility of the secondary and tertiary hospital system; the size, training, and experience of the HN's pool of medical and nursing professionals; and the status of the HN or US-backed groups military hospitalization system.*)

(3) Combat health logistics to include blood management. (*Medical supply and maintenance of medical equipment are of significant importance in developing nations. Combat health support planners must ensure that the humanitarian assistance programs do not introduce the population to medicines, such as antibiotics, that will not be available to the people once US support is withdrawn. In the same line of thought, providing high technology medical equipment may not accomplish what was intended if the HN does not have the trained technicians to operate it, or to repair or replace the equipment once it malfunctions. It should also include a discussion on the availability of a safe blood supply for US forces or establishing a blood procurement, processing, and banking program for the HN or US-backed group.*)

(4) Medical laboratory service. (*For US forces, medical laboratory service may be provided outside of the AO; coordination for transportation of specimens and resulting reports must be established. Within the HN, the considerations may include developing a military medical laboratory system or expanding the functions of the existing laboratories to process environmental specimens or suspected BW and CW agents.*)

(5) Veterinary services. (*The care and treatment of government-owned animals, food procurement, food inspection, and nation assistance programs to increase the productivity and value of the HN's livestock* [*refer to Chapter 4*] *can be included.*)

(Classification)

(Classification)

(6) Preventive medicine services. (*These services are important in protecting deployed US forces as well as tools used to increase the quality of life of the HN population or US-backed groups* [*refer to Chapter 4*].)

(7) Dental services. (*This could include dental programs coming under humanitarian assistance or nation assistance operations* [*refer to Chapter 4*].)

(8) Command, control, and communications. (*In stability and support operations, it is important that cooperative leadership or clear and concise lines of command* [*within the military*] *are established and that military assistance is provided in consonance with the other agencies involved in the operation* [*ambassador, country team, USAID, and other US agencies*]. *In assessing the HN military needs, the establishment of both command and technical channels for CHS operations is essential.*)

(9) Rehabilitative services. (*This includes the training required for HN rehabilitation personnel in OT and PT and development and training required to establish programs for the design and fabrication of prosthetic and orthotic devices.*)

(10) Combat stress control. (*This includes preventive measures to reduce the medical threat and intervention programs in response to specific incidents* [*such as a terrorist attack*].)

(11) Others.

c. Resources Available. (*Consider all sources available within the AO.*)

(1) Organic medical units and personnel. (*This includes US, allied, and coalition forces, HN, or US-backed groups resources, or assistance available through the embassy.*)

(2) Attached medical units and personnel.

(3) Supporting medical units. (*This could include support provided by US, allied, or coalition forces outside of the immediate AO, such as hospitalization provided in another country.*)

(4) Civil public health capabilities and resources. (*In stability and support operations, this resource may be the focus of the operation. Assessment as to quality, quantity, and type of resources play an important role in shaping many of the operations conducted. This element may also include any interagency, NGOs, and PVOs resources in the AO. Coordination for support and EMT is required when civilian casualties are generated due to military actions.*)

(5) Detained opposition medical personnel.

(6) Medical supplies and equipment. (*Considerations should include the HN's ability to use and service equipment and the availability of medicines within the HN once US support is withdrawn.*)

(Classification)

(Classification)

(7) Medical troop ceiling.

d. Courses of Action. (*As a result of the above considerations and analysis, determine and list all logical COAs which support the commander's OPLAN and accomplish the CHS or medical operation mission. Consider all ROEs, TSOPs* [*Appendix P*]*, policies, directives, US, HN, or international laws, and procedures in effect. Courses of action are expressed in terms of* ***WHAT***, ***WHERE***, ***WHEN***, ***HOW***, *and* ***WHY***.)

4. EVALUATION AND COMPARISON OF COURSES OF ACTION

a. *Compare the probable outcome of each COA to determine which one offers the best chance of success. This may be done in two steps:*

(1) *Determine and state those anticipated difficulties which will have a different effect on the COA.*

(2) *Evaluate each COA against each significant difficulty to determine strengths and weaknesses inherent in each.*

b. *Compare all COAs listed in terms of significant advantages and disadvantages or in terms of the major considerations that emerged during the above evaluation.*

5. CONCLUSIONS

a. *Indicate whether the mission set forth in paragraph 1 can* (*cannot*) *be supported.*

b. *Indicate which COA can best be supported from the CHS standpoint.*

c. *List the limitations and deficiencies in the preferred COA that must be brought to the commander's attention.*

d. *List factors adversely affecting the health of the command.*

/*s*/ _____
Command Surgeon

Annexes (*as required*)

DISTRIBUTION: (*Is determined locally.*)

(Classification)

F-3. Sample Format for the Veterinary Estimate

(Classification)

Headquarters
Location
Date, time, and zone

VETERINARY ESTIMATE OF THE SITUATION

References: *List all maps, overlays, charts, or other documents required to understand the plan. Reference to a map will include the map series number and country or geographic area, if required; sheet number and name, if required; edition; and scale.*

1. MISSION (*Statement of specific veterinary mission in support of various operations* [*such as support for insurgency and counterinsurgency, nation assistance, combatting terrorism, peace support, or domestic support operations*].)

2. SITUATION AND CONSIDERATIONS

a. Enemy (Opposition) Situation/Negative Factors. (*Information contained in this section of the estimate is similar to that contained in paragraph F-2; however, it is tailored to veterinary concerns and can include such elements as the medical threat as it pertains to zoonotic animal diseases.*)

(1) Strength and disposition of animals.

(2) State of health of the animals and the threat concerning zoonotic diseases.

(3) Capabilities that affect the ability of the Veterinary Service to accomplish its mission. (*Such as NBC threat to subsistence.*)

b. Friendly Situation/Positive Factors. (*Information contained in this section of the estimate is similar to that contained in paragraph F-2; however, it is tailored to veterinary concerns.*)

(1) Size and posture of Class I supply system.

(2) Types of rations to be used. (*Meals, ready to eat require less manpower for inspection than do A Rations.*)

(3) Status and source of Class I supplies.

(Classification)

(Classification)

(4) Strength and disposition of government-owned animals.

(5) Status of veterinary supply.

(6) Reliance of the HN economy on its livestock and ranching industry, if applicable.

(7) Evacuation or retrograde of animals to CONUS, if applicable.

(8) Number and extent of civic action programs.

c. Characteristics of the Area of Operations. (*Information contained in this section of the estimate is similar to that contained in paragraph F-2; however, it is tailored to veterinary concerns.*)

(1) Terrain.

(2) Weather.

(3) Animal population (health, types, disposition [domestic, livestock, and wildlife]). (*This can include predators which can endanger livestock. Veterinary personnel can evaluate the local livestock for availability and suitability of a fresh food source. As the mission/theater expands so will the requirement for A Rations.*)

(4) Flora. (*This can include the agricultural products used for feed for the livestock; plant diseases which impact growth and availability of animal feed; or any local plants which adversely impact on the health of grazing animals.*)

(5) Zoonotic diseases posing a threat to the health of the command or the local population.

(6) Local food supply system.

(7) Location, quantity, and quality of indigenous veterinary services.

(8) Nuclear, biological, chemical, and DE weapons/devices. (*This includes the impact of these weapons/devices on food sources and supplies and the health of government-owned and indigenous animals.*)

(9) Animal diseases having a disruptive impact on the economy.

(10) Other. (*Customs, culture, economic, religious, and social considerations that affect the care and management of livestock can be included.*)

(Classification)

(Classification)

d. Strengths to be Supported. (*Normally a table is used to include food inspection support and animal support, if applicable.*)

(1) Army.

(2) Navy.

(3) Air Force.

(4) Marines.

(5) Coast Guard.

(6) Department of Defense civilians.

(7) Department of Defense civilian contractor personnel.

(8) Allied forces.

(9) Coalition forces.

(10) Enemy prisoners of war/detainees (if applicable). (*This may also include internment and resettlement operations.*)

(11) Indigenous civilians.

(12) Detainees.

(13) Retainees.

(14) Others. (*Include third country civilians and refugees in this subparagraph. Further, if this is an NEO, has DOS authorized pets to accompany the evacuees or must the animals be disposed of within the country?*)

e. Health of the Animals in the Command. (*In nation assistance operations or other operations which involve the care, treatment, and sustainment of nongovernment-owned animals, this paragraph is used to provide information on the targeted animal population.*)

(1) Origin of animals.

(2) Presence of disease.

(Classification)

(Classification)

(3) Status of immunizations. (*This can consider incentives to ensure livestock is immunized such as requiring livestock immunization to secure a bank loan as discussed in Chapter 4. It can also include the requirement to immunize the native populations domestic animals to reduce the threat of rabies to US forces*.)

(4) Status of diagnostic tests. (*This can include the accessibility of laboratory assets and any special handling requirements for specimens*.)

(5) Status of nutrition.

(6) Care and management.

(7) Fatigue.

f. Assumptions.

g. Special Factors. (*This can include coordination requirements with the HN or US-backed group, NGOs, PVOs, and other US agencies* [*USAID and the USDA*].)

3. ANALYSIS

a. Veterinary Service Personnel Estimate.

(1) Distribution of Class I installations.

(2) Distribution of subsistence (perishable and nonperishable).

(3) Extent of local procurement.

(4) Extent of inspection load of indigenous foods. (*This would apply in disaster relief, NEO, and possibly humanitarian and nation assistance operations if feeding the native population is required.*)

(5) Establishment of a food procurement system for the HN military or US-backed groups.

(6) Number of animal casualties.

(7) Evacuation of animal casualties.

b. Veterinary Support Requirements.

(1) Food inspection.

(Classification)

(Classification)

(2) Veterinary PVNTMED and veterinary public health.

(3) Veterinary supply/resupply.

(4) Hospital treatment.

(5) Evacuation. (*This is primarily for government-owned animals; however, in NEO, it could also include the evacuees pets*.)

(6) Other (civil-military). (*Establishing training programs, developing a Veterinary Service infrastructure, and developing economic programs in conjunction with the HN or civilian banking industry can be included. Coordination with HN veterinary personnel or Ministry of Health or Agriculture or other appropriate agencies is required.*)

c. Veterinary Resources Available.

(1) Organic veterinary personnel.

(2) Attached veterinary units.

(3) Supporting veterinary units.

(4) Veterinary personnel in CA units and Special Forces groups.

(5) Civil veterinary public health personnel.

(6) Veterinary troop ceiling.

(7) Veterinary personnel from other US agencies, allied forces, coalition partners, or HN.

(8) Status of veterinary supply/resupply.

d. Courses of Action. (*As a result of the above considerations and analysis, determine and list all logical COAs which will support the commander's OPLAN and accomplish the CHS mission. Consider all TSOPs, policies, and procedures in effect. Courses of action are expressed in terms of* ***WHAT***, ***WHEN***, ***WHERE***, ***HOW***, *and* ***WHY***.)

4. EVALUATION AND COMPARISON OF COURSES OF ACTION

a. *Determine the probable outcome of each COA listed in paragraph 3d* (*above*) *when opposed by each significant difficulty identified. This may be done in two steps:*

(Classification)

(Classification)

(1) *Determine and state those anticipated difficulties that will have an equal effect on the COAs listed.*

(2) *Evaluate each COA against each significant difficulty to determine strengths and weaknesses inherent in each.*

b. *Compare all COAs listed in terms of significant advantages and disadvantages or in terms of the major considerations that emerged during the above evaluation.*

5. CONCLUSIONS

a. *Indicate whether the mission set forth in paragraph 1* (*above*) *can or cannot be supported.*

b. *Indicate which COA can best be supported from the Veterinary Service standpoint.*

c. *Indicate the disadvantages of nonselected COAs.*

d. *List the deficiencies in the preferred COA that must be brought to the attention of the commander.*

/*s*/ _____
Veterinary Staff Officer

Annexes (*as required*)

DISTRIBUTION: (*Is determined locally and includes the command surgeon.*)

(Classification)

F-4. Sample Format for the Preventive Medicine Estimate

(Classification)

Headquarters
Location
Date, time, and zone

PREVENTIVE MEDICINE ESTIMATE OF THE SITUATION

References: *List all maps, overlays, charts, or other documents required to understand the plan. References to a map will include the map series number and country or geographic area, if required; sheet number and name, if required; edition; and scale.*

1. MISSION (*Statement of the specific PVNTMED mission in support of various activities* [*such as support for insurgency and counterinsurgency, combatting terrorism, peace support, or domestic support operations*].)

2. SITUATION AND CONSIDERATIONS

a. Enemy (Opposition) Situation/Negative Factors. (*Information contained in this section of the estimate is similar to that contained in paragraph F-2; however, it is tailored to PVNTMED concerns.*)

(1) Communicable diseases. (*This should include endemic and epidemic diseases and their impact on mission effectiveness.*)

(2) Sanitation levels. (*This can include the oppositions ability/resources to raise/provide for standards of sanitation for the populace.*)

(3) Public health capabilities. (*This can include the opposition's ability to provide primary care and health development programs, such as well baby clinics; to conduct epidemiological investigations; to provide guidance on water treatment/purification; to provide guidance on waste disposal; and to provide inspection of food service operations.*)

(4) Immunization status. (*This can include both the opposition and general public, especially children. Does the opposition have the resources available to provide immunizations to their forces and the populace? Do they possess special immunizations/prophylaxis to protect their forces from potential BW agents?*)

(5) Level of field sanitation training.

(Classification)

(Classification)

(6) Nuclear, biological, and chemical and DE capabilities. (*This can include the oppositions ability to employ weapons of mass destruction, disperse biological agents, disseminate radioactive material, and employ DE devices/weapons*.)

b. Friendly Situation/Positive Factors.

(1) Status of individual and unit PVNTMED supplies.

(2) Operational situation. (*Factors such as the state of sanitation, type of billeting, and reliance on local economy for food and water will dictate the PVNTMED support requirements. Are the available sources sufficient to support US forces, allies, coalition partners, HN forces, and domestic and humanitarian assistance operations? If not, what will be the source of potable water?*)

(3) Types of rations used. (*In stability and support operations, units may have to rely on local vendors for food items, caution should be exercised when relying on these food supplies. Veterinary inspection support is essential to ensure wholesomeness and quality*.)

(4) Unit PVNTMED readiness.

(a) Field sanitation team training and equipment.

(b) Individual and unit PMM training and enforcement.

(5) Potable water and ice.

(a) Sufficient production and distribution units.

(b) Sufficient availability and quantity.

(c) Access to and availability of clean water in HN communities.

(d) Inspection/certification of water and ice sources and supplies.

(6) Availability of aircraft for aerial spray operations.

(7) Status of HN and domestic public health system (*to include health education programs*).

(8) Status of sanitation facilities.

(9) Status of immunizations (*especially for children*).

(10) Off-limit establishments.

(Classification)

(Classification)

c. Characteristics of the Area of Operations.

(1) Terrain. (*Discuss the following questions.*)

(a) Does the AO favor arthropod/rodent populations? (*In MOUT, are there fields of rubble where rodents can flourish? Are there open sewers or drainage canals? Are there stagnant pools of water or open water storage containers* [*such as drums*]*?*)

(b) Is the AO at a high altitude, in a jungle, in the desert, or on mountainous terrain?

(c) Is water available? (*What are the requirements for treatment and purification? Is it plentiful? Is it easily accessible?*)

(d) How will the terrain affect pest management operations? (*Are there low-lying areas where water can accumulate? Are there caves where bats can roost?*)

(2) Climate and weather. (*Discuss the following questions.*)

(a) Will the season affect disease transmission? (*Upper respiratory infections in the winter months; increased cases of malaria during rainy season.*)

(b) Will the season affect heat or cold injuries? (*How long will it take to acclimatize the troops to the AO? Is heat complicated with high/low humidity? Will exposure to cold be complicated by high winds? Will cold injuries be complicated by high-altitudes? Will sunburn/windburn or snow blindness be factors?*)

(c) Will the season affect disease vectors? (*Are arthropod vectors or pests more prevalent during the operational period in the AO?*)

(d) Will the season affect the water supply? (*Amount of rainfall such as flood or drought.*)

(e) Will the season affect pest management operations?

(3) Civilian population. (*Discuss the following subjects. There may be different subpopulations within the civilian community with different characteristics than other groups such as refugees from another country or displaced persons from the surrounding countryside.*)

(a) Endemic diseases (*especially those of military significance*).

(b) Epidemic diseases (*especially those of military significance*).

(Classification)

(Classification)

(c) Sources of disease/illness on the main supply route (*such as restaurants, lodging, or swampy areas*).

(d) Immunization status (*among the adult population; among the pediatric population*).

(e) Water treatment standards. (*Do standards exist? Is water treatment a common practice?*)

(f) Waste disposal practices. (*Do community sanitary facilities exist? Is the water source protected from contamination? Is garbage collected and disposed of in a sanitary landfill?*)

(g) Nutritional standards. (*In the short term* [*food supplies and availability affected by outbreaks of violence*]*? In the long term* [*is a famine occurring*]*? Can the average family afford an adequate diet?*)

(h) Civilian medical support and public health system. (*This should include capabilities/ deficiencies, facilities, and resources.*)

(i) Chemical hazards from industrial operations.

(j) Radiation hazards from nuclear power plants or other sources.

(k) Biological hazards from medical research and treatment operations.

(4) Flora and fauna. (*Discuss the following subjects.*)

(a) Arthropods vectors in the AO.

(b) Arthropods vectors resistant to pesticides.

(c) Venomous animals and insects.

(d) Poisonous plants.

(e) Rodents.

(5) Enemy prisoners of war and/or detainees, if applicable. (*May also include internment and resettlement operations. Discuss the following subjects.*)

(a) Presence of disease.

(Classification)

(Classification)

(b) Number of detained public health officers.

(c) Disease immunization status.

(d) Nutritional standards.

(6) Other. (*This could include cultural, religious, or ethnic practices which impact in the PVNTMED arena.*)

d. Strengths to be Supported.

(1) Army.

(2) Navy.

(3) Air Force.

(4) Marines.

(5) Coast Guard.

(6) Allied forces.

(7) Coalition forces.

(8) Host-nation forces.

(9) Enemy prisoners of war, if applicable. (*May also include internment and resettlement operations.*)

(10) Indigenous civilians. (*This category is important if planning humanitarian assistance programs.*)

(11) Detainees.

(12) Retainees.

(13) Others. (*This can include DOD civilian employees and contractors, third country civilians, NGOs, PVOs, and refugees.*)

e. Health Status of the Command. (*Discuss the following subjects.*)

(Classification)

(Classification)

(1) Origin of the troops. (*This is of particular importance in multinational operations as the forces from different nations will have different endemic diseases than those in the AO or from soldiers from other nations. Are they acclimated to the environment* [*heat, cold, altitude*]*?*)

(2) Presence of disease. (*Is the unit experiencing an outbreak of disease? Is it an endemic disease or potentially the effects from a BW agent?*)

(3) Immunization status. (*Are the troops from all participating nations immunized for the same diseases? If not, what are the differences? Are all immunizations current?*)

(4) Status of nutrition. (*What is the diet of the troops and how long have they been consuming it* [*such as MREs for 2 weeks*]*?*)

(5) Clothing and equipment. (*This can include the availability of protective equipment such as insect netting and insect repellent or special clothing for extreme environmental conditions*.)

(6) Fatigue and resistance to disease. (*Are sleep plans developed and implemented? Are there other factors contributing to fatigue* [*such as jet lag*]*?*)

(7) Other. (*Availability of prophylaxis*.)

f. Assumptions.

(1) (*Is the assumption really necessary for the solution?*)

(2) (*Will the results change if the assumptions are not made?*)

g. Special Factors. (*Coordination requirements with HN or US-backed group, NGOs, PVOs, and other US agencies. Additionally, the impact of culture, customs, or religious beliefs/practices on providing PVNTMED services should be discussed.*)

3. ANALYSIS

a. Estimates.

(1) Tasks involving arthropods and rodents.

(a) Disease and nonbattle injury threat assessment.

(b) Survey and identification of requirements.

(Classification)

(Classification)

(c) Control requirements.

(2) Tasks involving environmental health.

(a) Heat.

(b) Cold.

(c) Water and ice.

(d) Sanitation.

(e) Waste disposal.

(f) Altitude.

(3) Tasks involving disease.

(a) Epidemiology. (*Are laboratory resources available to support epidemiological investigations?*)

(b) Immunizations. (*Are they current? In nation assistance and humanitarian assistance operations, are they available to provide to the civilian population?*)

(c) Prophylaxis. (*Are supplies sufficient for the operation? Has a program been instituted to ensure prophylaxis are taken on a scheduled basis* [*such as antimalarial tablets taken every Friday morning with breakfast*]*?*)

b. Support Requirements.

(1) Supplies. (*Are on-hand supplies sufficient to meet the requirements? What is the availability/accessibility of resupply? Have unforeseen requirements been established that were not previously planned for? If so, what are their impact?*)

(2) Equipment. (*Is equipment on hand and serviceable? Are repair parts and maintenance support available?*)

(3) Civil and military support.

c. Resources Available.

(Classification)

(Classification)

(1) Organic PVNTMED personnel.

(2) Attached PVNTMED personnel.

(3) Supporting PVNTMED personnel.

(4) Status of unit field sanitation teams.

(5) Other Services.

(6) Allied forces.

(7) Coalition forces

(8) Host nation.

(9) Civilian public health personnel.

(10) Detained enemy (opposition) health personnel, if applicable.

(11) Preventive medicine troop ceiling. (*Discuss the impact* [*either negative or positive*] *that the troop ceiling has on mission accomplishment.*)

(12) Preventive medicine supply status.

d. Courses of Action. (*Determine, as a result of the above analysis, all logical COAs which support the commander's OPLAN and accomplish the CHS mission. Courses of action are expressed in terms of* ***WHAT***, ***WHEN***, ***WHERE***, ***HOW***, *and* ***WHY***.)

4. EVALUATION AND COMPARISON OF COURSES OF ACTION

a. *Determine the probable outcome of each COA listed in paragraph 3d* (*above*) *when opposed by each significant difficulty identified. This may be come in two steps:*

(1) *Determine and state those anticipated difficulties that will have an equal effect on the COAs listed.*

(2) *Evaluate each COA against each significant difficulty to determine strengths and weaknesses inherent in each.*

(Classification)

(Classification)

b. *Compare all COAs listed in terms of significant advantages and disadvantages or in terms of the major considerations that emerged during the above evaluations*.

5. CONCLUSIONS

a. *Indicate whether the mission set forth in paragraph 1* (*above*) *can or cannot be supported*.

b. *Indicate which COA can best be supported from the Veterinary Service standpoint*.

c. *Indicate the disadvantages of nonselected COAs*.

d. *List the deficiencies in the preferred COA that must be brought to the attention of the commander*.

/*s*/ _____
Preventive Medicine Staff Officer

Annexes (*as required*)

DISTRIBUTION: (*Is determined locally and includes the command surgeon*.)

(Classification)

F-5. Sample Format for the Dental Estimate

(Classification)

Headquarters
Location
Date, time, and zone

DENTAL ESTIMATE OF THE SITUATION

References: *List all maps, overlays, charts, or other documents required to understand the plan. Reference to a map will include the map series number and country or geographic area, if required; sheet number and name, if required; edition; and scale.*

1. MISSION (*Statement of the specific dental mission in support of various activities* [*such as support for insurgency and counterinsurgency, combatting terrorism, peace support, or domestic support operations*].)

2. SITUATION AND CONSIDERATIONS

a. Enemy (Opposition) Situation/Negative Factors. (*Information contained in this section of the estimate is similar to that contained in paragraph F-2; however, it is tailored to dental concerns.*)

(1) Strength and disposition.

(2) Combat efficiency.

(3) Capabilities.

(4) Logistics situation.

(5) State of health. (*This could include the impact that dental disease has on the opposition's readiness.*)

(6) Weapons.

b. Friendly Situation/Positive Factors. (*Information contained in this section of the estimate is similar to that contained in paragraph F-2; however, it is tailored to dental concerns.*)

(1) Strength and disposition.

(2) Combat efficiency.

(Classification)

(Classification)

(3) Present and projected operations. (*This category can include limitations and restrictions placed on the operation by the HN, or due to customs/traditions and religious beliefs.*)

(4) Logistics situation.

(5) Weapons.

c. Characteristics of the Area of Operations. (*Information in this section of the estimate is similar to that contained in paragraph F-2; however, it is tailored to dental concerns.*)

(1) Terrain.

(2) Weather.

(3) Civilian population. (*Status of oral health and factors adversely affecting oral health should be included.*)

(4) Local resources. (*This can include access to and availability of local* [*civilian, HN military, or US-backed group*] *dental services.*)

(5) Other. (*This can include the state of nutrition and diet and its impact on oral health or availability of fluoride in the water source.*)

d. Strengths to be Supported.

(1) Army.

(2) Navy.

(3) Air Force.

(4) Marines.

(5) Coast Guard.

(6) Allied forces.

(7) Coalition forces.

(8) Host-nation forces.

(Classification)

(Classification)

(9) Enemy prisoners of war (if applicable). (*May also include internment and resettlement operations*.)

(10) Civilians. (*This category is important when planning for humanitarian assistance or nation assistance operations*.)

(11) Detainees.

(12) Retainees.

(13) Others. (*This category can include DOD civilian employees, third country civilians, NGOs, PVOs, other US agencies, and refugees*.)

e. Oral Health of the Command (or Population Supported).

(1) Emergency rate.

(a) Preventable.

(b) Nonpreventable.

(2) Soldier's individual level of oral health.

(3) Unit dental readiness indexes.

(4) Dental readiness status of soldiers deploying into the theater.

(a) Individuals.

(b) Units.

(5) Dental preventive measures and educational programs currently available.

f. Assumptions.

g. Special Factors. (*Coordination requirements with HN or US-backed groups, NGOs* [*religious groups or international health groups*]*, and other US agencies. The impact of culture, customs, or religious beliefs on providing dental services can also be included.*)

3. ANALYSIS

(Classification)

(Classification)

a. Personnel Estimate.

b. Patient Estimates. (*Indicate rates and numbers by type of unit, or by category of activity* [*such as humanitarian assistance or disaster relief operations*].)

c. Support Requirements and Resources Available.

(1) Supply and equipment.

(a) Requirements. (*The requirements for electricity to run equipment and quantities of dental materials and medications are examples of information to include.*)

(b) Availability. (*Source of logistics supply and resupply should be included.*)

(c) Limiting factors. (*This can include the effect the austere environment has on the dental mission, isolation of villages, or other factors impacting on performing the dental mission.*)

(2) Transportation.

(a) Requirements. (*This can include transportation requirements for both the dental providers and the civilian population to reach a treatment area.*)

(b) Availability. (*Whether the transportation assets are organic or if another agency is providing transportation.*)

(c) Limiting factors. (*For example, the requirement to reach a village by foot or on a pack animal may limit the amount and type of equipment which can be used.*)

d. Evacuation.

(1) Requirements. (*This could include considerations of what is available through allied forces, coalition forces, HN* [*civilian and military*]*, or US-backed group resources.*)

(2) Availability.

(3) Limiting factors. (*This can include information for evacuation of US, allied, or coalition forces and evacuation requirements for indigenous civilians for more definitive care within the HN or abroad.*)

e. Hospitalization.

(Classification)

(Classification)

(1) Requirements.

(2) Availability.

(3) Limiting factors.

f. Miscellaneous. (*Indicate any special or unusual organizational or other logistical considerations.*)

g. Special Factors. (*This can include coordination requirements with the HN or US-backed groups, NGOs, PVOs, and other US agencies.*)

h. Courses of Action. (*Determine, as a result of the above analysis, all logical COAs which support the commander's OPLAN and accomplish the CHS mission. Courses of action are expressed in terms of* ***WHAT***, ***WHEN***, ***WHERE***, ***HOW***, *and* ***WHY***.)

4. EVALUATION AND COMPARISON OF COURSES OF ACTION

a. *Determine the probable outcome of each COA listed in paragraph 3h* (*above*) *when opposed by each significant difficulty identified.*

b. *Compare all significant advantages and disadvantages.*

5. CONCLUSIONS

a. *Indicate whether the mission set forth in paragraph 1 can* (*or cannot*) *be supported.*

b. *Indicate which COA can best be supported from the dental service standpoint.*

c. *Indicate the disadvantages of nonselected COAs.*

d. *List the deficiencies in the preferred COA that must be brought to the attention of the commander.*

/s/ _____
Dental Surgeon

Annexes (*as required*)

DISTRIBUTION: (*Is determined locally and includes the command surgeon.*)

(Classification)

F-6. Sample Format for the Combat Stress Control Estimate

(Classification)

Headquarters
Place
Date, time, and zone

COMBAT STRESS CONTROL ESTIMATE OF THE SITUATION

References: *Maps, overlays, charts, and other documents required to understand the plan. Reference to a map will include the map series number and country or geographical area, if required; sheet number and name, if required; edition; and scale.*

1. MISSION (*Statement of the specific CSC mission for the operation. Most of the examples provided in this estimate relate to the morale and mission success of US forces employed in stability and support operational scenarios. If the CSC mission is to provide intervention with disaster victims or victims of terrorist incidents, the considerations used in this estimate would require revision.*)

2. SITUATION AND CONSIDERATIONS

a. Enemy (Opposition) Situation/Negative Factors. (*Information contained in this section of the estimate is similar to that contained in paragraph F-2; however, it is tailored to CSC concerns*).

(1) Strength and disposition. (*This may include strongholds, areas sympathetic to the opposition group, or the size and type of organization of the opposition group.*)

(2) Combat efficiency. (*This may include information on how skilled and experienced; how committed to the cause and/or country for which they are fighting; how long they have been fighting; and how attrited their forces are.*)

(3) Capabilities. (*This can include the potential for terrorist activities. Stress factors for US soldiers dramatically increase if terrorist activities target US facilities, installations, or troops.*)

(4) Logistics situation. (*This could include any information on the enemy logistics situation which could adversely impact on soldier morale; for example, the enemy subsisting on more fresh rations* [*fruits, vegetables, meats*] *while US forces or US-backed groups having to subsist solely on MREs.*)

(5) State of health. (*This should include information on any potential disease threat* [*contagious diseases*] *from captured/surrendered soldiers and/or detainees which might have an adverse psychological impact on US forces and US-backed groups.*)

(Classification)

(Classification)

(6) Weapons. (*This should include information on the potential for use of conventional, NBC, and DE weapons/devices. It should include information on any weapons systems and employment techniques that would have a significant psychological impact on US forces or US-backed groups.*)

b. Friendly Situation/Positive Factors. (*Information contained in this section of the estimate is similar to that contained in paragraph F-2; however, it is tailored to CSC concerns.*)

(1) Strength and disposition.

(2) Combat efficiency. (*This may include information on esprit de corps, unit cohesiveness, level of training, and other such factors.*)

(3) Present and projected operations. (*This includes information on the experience level of the soldiers and leaders and the confidence they have in completing the mission successfully. The present and projected operations may not include conducting military battles as they may only involve providing humanitarian assistance; for example, it should include information on their confidence in their ability to successfully perform the mission, their attitude toward the "worthiness" of the mission, or other such concerns. Further, soldier morale is affected by the way they perceive the American public views the mission. If the perception is that the American people do not support the mission, the greater the stress soldiers will experience.*)

(4) Logistics situation. (*This should include information on the soldier's confidence level of the system to provide for the necessities of life and any specific shortages which are affecting morale.*)

(5) Weapons. (*This may or may not be a factor in a specific mission. However, the ROE* [*especially on self-defense*] *should be discussed if they are restrictive and affecting morale or eroding the confidence of the troops.*)

c. Characteristics of the Area of Operations. (*Information contained in this section is similar to that contained in paragraph F-2; however, it is tailored to CSC concerns.*)

(1) Terrain. (*Does it restrict troop activities? Does it make troops feel isolated* [*such as performing duty at a relay station on top of a mountain*]*? Does it make performing duty more difficult* [*wading through swamps, traversing rocky cliffs*]*? Is there a threat from earthquakes or volcanic eruptions?*)

(2) Weather. (*Does it restrict troop activities? Does it make performing duty more difficult* [*such as continual rains while performing guard duty*]*? Is there a continuing threat from inclement weather* [*hurricanes, typhoons, or tornadoes*]*?*)

(3) Civilian population. (*Are the US forces welcome in the country? Do civilians see the soldiers as performing a needed duty? Are civilians openly hostile to the soldiers? What are the differences in customs, language, and religious beliefs?*)

(Classification)

(Classification)

(4) Flora and fauna. (*Do the soldiers feel safe from or threatened by the indigenous animals* [*snakes, large predators*]*? Are there poisonous plants/animals that the soldiers must be cautious of?*)

(5) Local resources. (*This can include the availability of mental health assets within the civilian community, or it could include natural resources within the community for recreational use by soldiers to increase their morale.*)

(6) Other. (*This can include any factors not considered above which impact the morale and well-being of the soldiers.*)

d. Strengths to be Supported. (*Information contained in this section is similar to that contained in paragraph F-2. Some categories will require expansion as beneficiaries will vary with the different type of stability and support operational activity.*)

(1) Army.

(2) Navy.

(3) Air Force.

(4) Marines.

(5) Coast Guard.

(6) Allied forces.

(7) Coalition forces.

(8) Enemy prisoners of war/detainees. (*May also include internment and resettlement operations.*)

(9) Indigenous civilians.

(10) Retainees.

(11) Internees.

(12) Others. (*This may include such groups as refugees, third country nationals, insurgents or US-backed groups, disaster victims, NGOs, PVOs, DOD civilian employees and contractors, rescue workers, and care givers.*)

(Classification)

(Classification)

e. Health of the Command.

(1) Acclimatization. (*This usually refers to the physical acclimatization of the troops to the weather, altitude, and/or other environmental conditions. In the CSC arena during stability and support operations, it could be expanded to cover the adjustment to the culture, political situation, or other socioeconomic factors.*)

(2) Presence of disease. (*This can include the endemic and epidemic diseases of the AO, especially those which the troops have a fear of being exposed to such as the acquired immunodeficiency syndrome or other sexually transmitted diseases.*)

(3) Status of immunizations. (*This is of particular importance as most noneffectiveness in stability and support operations is produced by DNBI rather than wounds. Emphasis should be on all PMM the individual can take to mitigate the effects of endemic and epidemic diseases.*)

(4) Status of nutrition. (*The types of rations soldiers have to subsist on and the length of time required to subsist on field rations* [*MREs*] *will have a significant impact on morale.*)

(5) Clothing and equipment.

(6) Fatigue. (*Can include such factors as sleep loss, physical overwork, and jet lag.*)

(7) Morale.

(8) Status of training. (*This can include the attitude of the soldier toward his training, such as whether he feels competent in performing his duties.*)

(9) Other. (*This can include home-front issues and concerns.*)

f. Assumptions. (*Assumptions may be required as a basis for initiating or preparing the estimate. Assumptions are modified as factual data becomes available.*)

g. Special Factors. (*Mention items of special importance to the particular operation to be supported.*)

3. ANALYSIS

a. Patient Estimates.

(1) Number of patients anticipated.

(2) Distribution of patients within the AO.

(Classification)

(Classification)

(3) Distribution during time of the operation.

(4) Possible mass casualties.

(5) Lines of patient drift and evacuation. (*This could apply to operations involving some level of conflict or disaster relief operations.*)

b. Support Requirements. (*This information is discussed from the perspective of what impact it has on CSC operations.*)

(1) Patient evacuation and medical regulating.

(2) Hospitalization.

(3) Combat health logistics.

(4) Medical laboratory services.

(5) Dental services.

(6) Veterinary services.

(7) Preventive medicine services.

(8) Area medical support.

(9) Command, control, communications, computers, and intelligence.

c. Resources Available.

(1) Mental health personnel organic to deployed units.

(2) Attached CSC/MH medical units and personnel.

(3) Supporting CSC units and CHS assets.

(4) Air Force resources.

(5) Navy resources.

(6) Allied MH assets.

(Classification)

(Classification)

(7) Coalition MH assets.

(8) Civilian public health resources.

(9) Combat health support/CSC troop ceiling.

d. Courses of Action. (*As a result of the above considerations and analysis, determine and list all logical COAs which will support the commander's OPLAN and accomplish the CHS/CSC mission. Consider all SOPs, policies, and procedures in effect. Courses of action are expressed in terms of* ***WHAT***, ***WHEN***, ***WHERE***, ***HOW****, and* ***WHY***.)

4. EVACUATION AND COMPARISON OF COURSES OF ACTION

a. *Compare the probable outcome of each COA to determine which one offers the best chance of success. This may be done in two steps:*

(1) *Determine and state those anticipated difficulties or difficulty patterns which will have a different effect on the COAs listed.*

(2) *Evaluate each COA against each significant difficulty or difficulty pattern to determine strengths and weaknesses inherent in each.*

b. *Compare all COAs listed in terms of significant advantages and disadvantages, or in terms of the major considerations that emerged during the above evaluation.*

5. CONCLUSIONS

a. *Indicate whether the mission set forth in paragraph 1 can* (*cannot*) *be supported.*

b. *Indicate which COA can best be supported from the CSC standpoint.*

c. *List the limitations and deficiencies in the preferred COA that must be brought to the commander's attention.*

d. *List factors adversely affecting the CSC health of the command.*

/*s*/ _____
(*as appropriate*)

Annexes (*as required*)

DISTRIBUTION: (*Is determined locally and includes the command surgeon.*)

(Classification)

F-7. Sample Format for the Combat Health Logistics Estimate

(Classification)

Headquarters
Place
Date, time, and zone

COMBAT HEALTH LOGISTICS ESTIMATE OF THE SITUATION

References: *Maps, overlays, charts, and other documents required to understand the plan. Reference to a map will include the map series number and country or geographical area, if required; sheet number and name, if required; edition; and scale.*

1. MISSION (*Statement of the specific CHL mission in support of various activities* [*such as nation assistance, humanitarian assistance, or peace support operations*].)

2. SITUATION AND CONSIDERATIONS

a. Enemy (Opposition) Situation/Negative Factors.

(1) Strength and disposition. (*Besides discussing the size of the opposition forces, this paragraph can include information on CHL type organizations, civilian or nongovernmental agencies fulfilling this role, or any other information on the size and sophistication of the CHL employed by the opposition.*)

(2) Capabilities. (*This paragraph can discuss the enemy/opposition's ability to interdict the CHL LOC and the potential to disrupt or delay CHL operations. Negative factors could also include the potential recurrence of earthquakes, flooding, or other natural calamities.*)

(3) Logistics situation.

(a) General supply. (*This includes information on the status of general supply and maintenance as it would impact on the CHL function or on the state of health of the opposition.*)

(b) Combat health logistics. (*This includes information on the operation of the enemy/opposition CHL system. For example, the development of an insurgent medical system is usually rudimentary with inadequate supplies of antibiotics and other medications. These shortages would have an impact on the mortality rate of wounded and diseased personnel.*)

(Classification)

(Classification)

(4) State of health. (*This can be an indicator of the demand that will be placed on the enemy/opposition for Class VIII supplies, equipment, and maintenance and on the US for the care of EPW/detained patients*.)

(5) Weapons. (*This paragraph can discuss the enemy's/opposition's potential use of NBC and DE weapons/devices which can result in the contamination and/or destruction of Class VIII materiel. It can also discuss the potential threat to CHL personnel while engaged in CHL activities* [*transportation and distribution*].)

b. Friendly Situation/Positive Factors.

(1) Strength and disposition. (*This can discuss the numbers and types of CHL units/personnel deployed to the area; the designation of SIMLM; anticipated changes* [*arrival/departure of units*]*; and resources from other Services, allies, coalition forces, HN, DOD civilian employees and contractors, NGOs, and PVOs*.)

(2) Efficiency. (*This paragraph can discuss the organization and operations of existing CHL units/personnel. It may also include any CHL activities conducted by civilian and nongovernmental agencies; the availability and suitability of contracting supplies, equipment, and repair services. This is particularly important in operations such as disaster relief or humanitarian assistance where supplies of all different types are donated and shipped to the AO. Further, this paragraph can discuss resupply procedures if the mission is conducted under the auspices of another organization* [*such as the UN*].)

(3) Present and projected missions. (*This can include information concerning the current operation; anticipated withdrawal of the US assistance and/or the hand-off of the function to the civilian government and/or other agency; and any follow-on missions*.)

(4) Logistic situation.

(a) General supply and services. (*This discussion should include any information on the general logistics situation that would impact on the accomplishment of the CHL mission. For example, if one of the vehicles is deadlined and cannot be repaired at the unit level and direct support maintenance is unavailable, the distribution mission of the CHL element would be affected*.)

(b) Combat health logistics.

1. Status of Class VIII materiel. (*This can include information on the current status of Class VIII supplies and equipment; number of days of supply to be carried; if push packages are to be used and for how long they will be used; anticipated changes in status* [*such as additional units being deployed*]*; any known shortages/delays in obtaining goods and services* [*back orders*]*; establishment of the Medical Standby Equipment Program policies/procedures for property exchange and establishment of a*

(Classification)

(Classification)

theater pool for return of equipment; and availability of supplies and services through allied, HN, coalition forces, NGOs, PVOs, UN agencies, and contract with local suppliers.)

2. Shipping and distribution. (*This can include information on the mode of transportation supply/resupply means will take* [*air, land, or sea*]*; anticipated time required to receive supplies from originating point; customs and other administrative requirements* [*such as agricultural inspections*]*; marking and manifesting shipping containers to clearly indicate contents and destination; anticipated problems* [*such as the depth of the port facility*]*; adequate airfields and runways* [*length of runway required for aircraft*]*; materiel handling equipment located at the airfield/seaport; and other such concerns*.)

3. Storage and handling requirements. (*This includes information on any special storing and handling requirements* [*such as refrigeration and/or ice for blood storage and distribution purposes*]*; availability of covered versus uncovered storage areas; controlled substance inventories or other requirements that impact on the operation; procedures for protecting supplies and equipment from contamination; and decontamination or replacement requirements if materiel becomes contaminated.*)

4. Optical fabrication. (*This includes information on optical fabrication requirements and capabilities; availability of these supplies and services in the HN civilian/military community or other forces/agencies participating in the operation; and capability to contract for services required.*)

5. Medical equipment maintenance. (*This includes requirements and capabilities for this support within the AO; contracting for services with HN and/or civilian community; availability of repair parts; disposition and replacement of equipment that cannot be repaired within the AO*.)

6. Single Integrated Medical Logistics Manager. (*This includes information on what agency is functioning in this capacity. If it is the Army, this discussion should include all pertinent aspects of this role and responsibilities; anticipated difficulties; and coordination and liaison requirements*.)

7. Abandoned medical materiel. (*This includes information on the receipt, storage, and redistribution of this materiel for use in treating EPW, detainees, and/or other recipients*.)

8. Donated medical supplies and equipment. (*In humanitarian assistance, disaster relief, and some nation assistance and insurgency/counterinsurgency operations, donated medical supplies and equipment may be the primary source of these supplies for the operation. These supplies and equipment will require receipt, inventory, storage, repackaging, and distribution. As these goods will arrive in various quantities, strengths* [*medication*]*, and packaging, they will take considerable effort to handle and distribute*.)

c. Characteristics of the Area of Operation.

(Classification)

(Classification)

(1) Terrain. (*This discussion should include information on the impact of the terrain on CHL operations* [*such as the existence of improved roads; mountains or other obstacles; waterways and depths of ports; and hostile terrain* [*deserts, swamps, or the like*] *It can also include information on the potential for earthquake or volcanic activity within the AO*.)

(2) Weather. (*This includes information on the impact of the weather on the storage and handling of materiel* [*especially heat/cold sensitive items*]*; acclimatization requirements for CHL*; *and impact on planned distribution operations* [*blizzards, torrential rains*].)

(3) Civilian population. (*This includes information on availability of labor; impact on CHL; nongovernmental agencies and/or groups; and groups/segments of the population either hostile or supportive of the US effort and their ability to disrupt/assist the mission*.)

(4) Flora and fauna. (*This can discuss any poisonous or toxic animals/plants* [*requirements for antitoxins and antivenoms*] *within the region and/or the threat from predatory animals*.)

(5) Local resources. (*This includes the availability of Class VIII items on the local economy and contracting for services and repairs*.)

(6) Other.

d. Strengths to be Supported.

(1) Army.

(2) Navy.

(3) Air Force.

(4) Marines.

(5) Coast Guard.

(6) Allied forces.

(7) Coalition forces.

(8) Enemy prisoners of war/detainees. (*May also include internment and resettlement operations*.)

(9) Indigenous civilians.

(Classification)

(Classification)

(10) Retainees.

(11) Internees.

(12) Others. (*This can include other governmental and nongovernmental agencies and PVOs. Most likely, this will occur in humanitarian assistance, disaster relief, and domestic support operations.*)

e. Health of the Command.

(1) Acclimatization of troops. (*Acclimation of CHL personnel is important because of the strenuous work involved with the handling of materiel. If sufficient time has not elapsed to ensure acclimation, leaders must ensure that adequate quantities of potable water are available.*)

(2) Presence of disease. (*This will affect the types and quantities of medications required for the mission.*)

(3) Status of immunizations. (*This may include immunizations that are required by the supported population which may impact on the types and quantities of requisitions to be processed.*)

(4) Status of nutrition. (*This can include special foods for supported forces due to religious beliefs.*)

(5) Clothing and equipment. (*This can include any special requirements imposed by geographic location or environmental factors.*)

(6) Fatigue. (*This factor will affect the efficiency of the organization. Sleep plans and rest schedules are important aspects of planning, especially in continuous operations. Some stability and support operational scenarios will initially require continuous operations.*)

(7) Morale.

(8) Status of training.

f. Assumptions.

g. Special Factors. (*This can include coordination requirements with agencies outside of the military.*)

3. ANALYSIS

a. Combat Health Logistics.

(Classification)

(Classification)

(1) Medical supplies. (*This can include an analysis of what types of supplies are on-hand, their availability in the local economy, capability to contract for supplies/services, requirements, and back orders; impact of terrain and environmental conditions on CHL operations; feasibility of introducing medications not available in HN and impact on HN medical infrastructure once US assistance is withdrawn.*)

(2) Medical equipment. (*This can include an analysis of what medical equipment is on-hand, their ability in the local economy, capability to contract for medical equipment, requirements, and back orders; impact of terrain and environmental conditions on the equipment; feasibility of introducing sophisticated medical equipment into the HN that cannot be adequately supported once US assistance is withdrawn.*)

(3) Optical fabrication. (*This can discuss location of support if assets are not available within the AO.*)

(4) Medical equipment maintenance. (*This includes an analysis of the organic capability versus ability to contract for services versus direct support/general support capability to accomplish the mission.*)

b. Support Requirements. (*These will vary dramatically depending upon the type of operation and the forces deployed. A clear understanding of who is being supported, where funding and/or reimbursement will be obtained, and legal guidance on the conduct of operations with NGOs and PVOs should be included. This paragraph can be further delineated into subparagraphs discussing specific support requirements for the operations.*)

c. Resources Available. (*This should include all available resources: Army supporting medical units, other Services, allies, coalition forces, HN or civilian, other governmental agencies, NGOs, and PVOs and any constraints/restrictions* [*such as a medical troop ceiling*]. *It can also include existing or planned construction of facilities.*)

d. Courses of Action. (*As a result of the above considerations and analysis, determine and list all logical COAs which support the commander's OPLAN and accomplish the CHS mission. Consider all TSOPs, policies, directives, US, HN, or international laws, and procedures in effect. Courses of action are expressed in terms of* ***WHAT***, ***WHERE***, ***WHEN***, ***HOW***, *and* ***WHY***.)

4. EVALUATION AND COMPARISON OF COURSES OF ACTION

a. *Compare the probable outcome of each COA to determine which one offers the best chance of success. This may be done in two steps.*

(1) *Determine and state those anticipated difficulties or difficulty patterns which will have an effect on the COAs.*

(Classification)

(Classification)

(2) *Evaluate each COA against each significant difficulty to determine strengths and weaknesses inherent in each.*

b. *Compare all COAs listed in terms of significant advantages and disadvantages or in terms of the major considerations that emerged during the above evaluation.*

5. CONCLUSIONS

a. *Indicate whether the mission set forth in paragraph 1 can* (*cannot*) *be supported.*

b. *Indicate which COA can best be supported from the CHL standpoint.*

c. *List the limitations and deficiencies in the preferred COA that must be brought to the commander's*/*command surgeon's attention.*

d. *List factors adversely affecting the combat health logistics mission.*

/*s*/ _____
(*as appropriate*)

Annexes (*as required*)

DISTRIBUTION: (*Is determined locally*)

(Classification)

Section II. COMBAT HEALTH SUPPORT PLAN

F-8. General

a. Once the CHS estimate is completed, the CHS planner can proceed with developing the CHS plan for the proposed operation. As with the estimate, the same planning process for developing the traditional CHS plan is used for stability and support operations.

b. In this section the format for the CHS plan and appropriate annexes is provided.

c. Paragraphs F-10 through F-14 provide the CHS plan format for veterinary, PVNTMED, dental, CSC, and CHL support.

F-9. Sample Format for the Combat Health Support Plan

(Classification)

Copy__ of__ copies
Headquarters
Location
Date, time, and zone

COMBAT HEALTH SUPPORT PLAN

References: *List all maps, overlays, charts, or other documents required to understand the plan. Reference to a map will include the map series number and country or geographic area, if required; sheet number and name, if required; edition; and scale.*

Time Zone Used Throughout the Plan: (*Included only if used as the initial plan or if a major organization is to be affected.*)

Task Organization: Annex A (Task Organization) (*Task organization may appear here, in paragraph 3, or in an annex.*)

1. SITUATION (*Provide information essential to understanding the plan.*)

a. Enemy (Opposition) Forces/Negative Factors. (*Emphasis on capabilities bearing on the plan by terrorist groups, insurgents, HN forces, or other opposition groups or political factions found in a particular country. This subparagraph is viewed as groups opposed to the US-backed or supported groups, HN, and US national interests. Also, in stability and support operational scenarios, information concerning grievances, causes for unrest, or other pertinent data can be included.*)

(Classification)

(Classification)

b. Friendly Forces/Positive Factors. (*This is addressed from the perspective of the HN or US-backed group and US national interests. Emphasis is also placed on CHS functions or medical operations and responsibilities for higher and adjacent units.*)

c. Attachments and Detachments. (*May be published as an annex pertaining to task organization. In a stability and support operational scenario, HN, other US agencies or military services, allies, coalition partners or US-backed groups who will participate in the operation can be indicated in this subparagraph.*)

d. Assumptions. (*Include the minimum required for the planning process.*)

2. MISSION (*Statement of the overall CHS mission and type of activity to be supported* [*insurgency and counterinsurgency, combatting terrorism, peace support, or domestic support operations*].)

3. EXECUTION

a. Surgeon's Concept of Support for the Combat Health Support Operation. (*First lettered subparagraph provides a concise overview of planned CHS.*)

b. Major Medical Command and Control Headquarters. *The second lettered subparagraph identifies the major medical control headquarters and lists the tasks or missions assigned to it.*)

c. Other Medical Units. (*The third and subsequent lettered subparagraphs identify the remaining medical units in turn and list their respective tasks and missions.*)

d. Evacuation Policy. (*The next to the last lettered subparagraph discusses the evacuation policy by phases of the operation, if applicable.*)

e. Coordinating Instructions. (*The final lettered subparagraph contains any coordinating instructions that may be appropriate to ensure continuity in CHS. This coordination should include requirements for interface with the other Services, allied forces, coalition forces, HN, US-backed groups, other US agencies, country team, NGOs, or PVOs, as deemed appropriate.*)

4. SERVICE SUPPORT

a. Supply. (*Refer to TSOP or another annex whenever practical.*)

(1) General supply. (*Provide special instructions applicable to CHS units. Also consider stockage levels for all classes of supply, as units will be operating in an austere environment and at extended distances from the full complement of CSS resources.*)

(2) Combat health logistics (to include blood and blood products). (*Provide special procedures applicable to the operation.*)

(Classification)

(Classification)

(a) Requirements. (*For sustaining the US, allied, coalition, or HN forces and other eligible beneficiaries are addressed in subparagraph* [*3*] *below*.)

(b) Procurement. (*Provide detailed information on resupply and stockage levels required and/or contracting support for the operation*.)

(c) Storage. (*Special procedures and equipment* [*such as refrigerators*] *requirements for maintaining storage and the appropriate shelf life of medical supplies in an austere environment should be included*.)

(d) Distribution. (*This should include the method of distribution and any limitations or restrictions that are applicable. Additionally, if special transportation requirements exist, they should also be noted*.)

(3) Supplies required to accomplish stability and support operational missions and not for the sustainment of the US, allied, coalition, or multinational force. (*This includes humanitarian assistance, disaster relief, or other stability and support operational missions*.)

(a) Requirements. (*Includes estimates of the population to be supported or the number of patients anticipated to be treated; materials required for teaching or training health professionals; and medical educational programs for the population at large*.)

(b) Procurement. (*The funding source should be identified and procedures for obtaining the supplies described, as well as any limitations or restrictions on the use of the supplies, should be included*.)

(c) Storage. (*Requirements for refrigeration or other special handling should be included*.)

(d) Distribution. (*Limitations and restrictions, as well as transportation requirements, should be included*.)

(e) Coordination. (*Interservice, allied force, US agencies, coalition forces, HN government, NGOs, and PVOs should be included*.)

(4) Combat health logistics activities. (*This includes the location of the medical supply activity supporting the AO and means of communicating requests for resupply*.)

(5) Salvaged medical equipment and supplies.

(a) (*For sustainment of the US forces*.)

(Classification)

(Classification)

(b) (*For sustainment of stability and support operational missions*.)

(6) Abandoned enemy (opposition) medical supplies, if applicable. (*Should include disposition instructions*.)

(7) Civilian medical supplies. (*Should include resources for operational missions and training activities*.)

(8) Other CHL matters.

b. Transportation and Movements. (*This includes medical use of various transportation means*.)

(1) General. (*Transportation in stability and support operational scenarios oftentimes includes moving the medical team from one treatment area or CHS mission area to another. Transportation is often a critical factor in accomplishing the stability and support operational mission*.)

(2) Ground. (*The availability of ground evacuation assets to sustain US forces should be discussed. Additionally, the assessment and development of a ground evacuation system and the training requirements for HN personnel* [*if applicable*] *can also be included. Coordination for use of allied, coalition, or HN forces evacuation assets should also be included*.)

(3) Rail. (*If available, the treatment locations could be established along the railway; or it could provide a means for the civilian population to travel to a treatment area or to move the medical team and equipment*.)

(4) Water. (*Considerations should include both inland and at sea transportation requirements or assets and the availability of shipboard facilities for evacuation and treatment*.)

(5) Air. (*The availability of aeromedical evacuation support for the supported force should be discussed. Additionally, the assessment of aeromedical evacuation requirements for a HN or US-backed group, the development of a medical evacuation system, and the training of appropriate personnel can be discussed depending upon the category of the stability and support operational mission*.)

(6) Movement control and traffic regulation, if applicable. (*This can include requirements for armed escorts; requirements for crossing international boundaries, convoy restrictions; or other circumstances affecting transport operations*.)

c. Services.

(1) Services to CHS units and facilities. (*Include information on the following services: laundry, bath, utilities, fire fighting, construction, real estate, graves registration, religious, personnel, and finance*.)

(Classification)

(Classification)

(2) Medical equipment maintenance.

(a) For the sustainment of US forces.

(b) For the sustainment of the stability and support operational mission (*including teaching medical equipment repair skills*).

d. Labor. (*Include policies, agreements, or arrangements on the use of civilian or other personnel for labor.*)

e. General Maintenance. (*This includes priority of maintenance and the location of repair facilities.*)

5. EVACUATION, TREATMENT, AND OTHER HEALTH SERVICES

a. Evacuation.

(1) Evacuation of supported US, allied, coalition, or HN forces. (*Include evacuation policy, medical regulating, en route medical care, and modes of transportation.*)

(a) Requirements. (*Include mass casualty situations.*)

(b) Units. (*Include information on the units providing this support and appropriate communications information.*)

(c) Other. (*This can include information on assets which may be used in an emergency, such as diplomatic flights.*)

(2) Evacuation of HN civilians or military, US-backed groups, or other categories of personnel. (*Include any limitations and restrictions.*)

(3) Assessing and developing an evacuation system for a HN or US-backed group. (*Include any limitations and restrictions.*)

(4) Other activities pertaining to evacuation functions in a stability and support operational scenario.

b. Treatment.

(1) Treatment of supported US, allied, coalition, or HN forces. (*Include arrangements for hospitalization, mass casualty situations, or other treatment considerations.*)

(a) Policies. (*Should address treatment and hospitalization policies to include civilians, EPW, detainees, or other category of personnel.*)

(Classification)

(Classification)

(b) Units. (*This includes information concerning the location, capabilities, and communications means of units providing support.*)

(c) Other. (*This can include information on other medical assets which may be used in an emergency, such as the embassy physician.*)

(2) Treatment of HN civilian or military personnel, US-backed groups, or other categories of personnel. (*This includes limitations and restrictions, hours of operation, and procedures to cover emergencies and mass casualty situations.*)

(3) Assessing and providing assistance in developing a primary care system for the HN or US-backed group. (*Include information on the adequacy of secondary and tertiary hospitals or other treatment-related missions.*)

c. Veterinary. (*Refer to paragraph F-10.*)

d. Preventive Medicine. (*Refer to paragraph F-11.*)

e. Dental. (*Refer to paragraph F-12.*)

f. Combat Stress Control. (*Refer to paragraph F-13*).

g. Combat Health Logistics. (*Refer to paragraph F-14.*)

h. Other Health Services. (*This includes information pertinent to the other CHS functions and services: medical laboratory service, fabrication of prosthetic and orthotic devices and required training; and command, control, and communications issues.*)

6. MISCELLANEOUS (*Address areas of support not previously mentioned which may be required or needed by subordinate elements in the execution of their respective CHS mission: command post locations, signal instructions, medical intelligence, claims, special reports that may be required, and international or HN support agreements affecting CHS.*)

/*s*/ _____
(Commander/Command Surgeon)

Appendixes

DISTRIBUTION: *(Is determined locally.)*

(Classification)

F-10. Sample Format for the Veterinary Service Portion of the Combat Health Support Plan

(Classification)

VETERINARY SERVICE

1. FOOD INSPECTION

   a. Procurement Inspection Policy.

   b. Abandoned Ration Inspection Policy.

   c. Nuclear, Biological, and Chemical Contaminated Ration Inspection Policy.

   d. Units. (*Provide location, hours of operation, or other pertinent information.*)

2. EVACUATION POLICY FOR GOVERNMENT-OWNED ANIMALS

   a. Evacuation Requirements.

   b. Units Participating in the Evacuation.

   c. Special Requirements for Animals Subjected to Nuclear, Biological, and Chemical Contamination.

3. HOSPITALIZATION FOR GOVERNMENT-OWNED ANIMALS (*Provide location of units providing this support.*)

4. VETERINARY OUTPATIENT SERVICES (*Provide treatment locations and hours of operation.*)

5. VETERINARY CARE PLANS AND PROGRAMS FOR HOST-NATION LIVESTOCK (*Provide information on animal husbandry programs when assistance is authorized.*)

6. TRAINING AND EDUCATION PROGRAMS FOR HOST-NATION VETERINARY PERSONNEL

7. DEVELOPMENT OF HOST-NATION MILITARY VETERINARY INFRASTRUCTURE

(Classification)

F-11. Sample Format for the Preventive Medicine Portion of the Combat Health Support Plan

(Classification)

PREVENTIVE MEDICINE SERVICES

1. MEDICAL THREAT (*From the PVNTMED estimate, give a brief overview of the threat.*)
   a. Environmental Injuries.
   b. Diarrhea.
   c. Arthropodborne, Foodborne, and Waterborne Diseases.
   d. Other.
2. CONCEPT OF SUPPORT
   a. Individuals.
   b. Units.
   c. Major Units.
   d. Preventive Medicine Teams/Detachments.
3. RESPONSIBILITIES
   a. General Policies. (*State policies applying to all soldiers within the command.*)
      (1) Individual PMM.
      (2) Specific policies.
   b. Unit Commanders.
      (1) Environmental injuries.
      (2) Diarrhea.
      (3) Biting arthropods.

(Classification)

(Classification)

(4) Other.

c. Specific Unit Commander's Responsibilities.

(1) Medical units.

(2) Quartermaster units.

(3) Subordinate units.

F-12. Sample Format for the Dental Service Portion of the Combat Health Support Plan

(Classification)

DENTAL SERVICE

1. ASSIGNMENT OF RESPONSIBILITIES (*Provide information concerning treatment locations, hours of operation, and services available at each location.*)

2. PREVENTION (*Include developing educational programs for the HN populace.*)

3. TREATMENT (*Include available services, humanitarian assistance programs, or other pertinent information.*)

4. ALTERNATE WARTIME ROLE

5. REPORTING (*Include all reports as required by command policy, regulation, HN agreements and laws, and unit TSOPs.*)

6. EVACUATION AND HOSPITALIZATION REQUIREMENTS

7. SUPPLIES AND TRAINING MATERIALS

8. MISCELLANEOUS DENTAL MATTERS

(Classification)

F-13. Sample Format for the Combat Stress Control Portion of the Combat Health Support Plan

(Classification)

COMBAT STRESS CONTROL

1. CONCEPT OF SUPPORT (*Indicate how MH personnel* [*teams*/*units*] *integrate their activities into the units supported.*)

2. TEAMS/UNITS (*Subparagraph for each CSC*/*MH team*/*unit.*)

a. Mission. (*May be several statements giving—*)

(1) Area/general support missions.

(2) Unit (group) support missions. (*This includes support to specific groups*/*units* [*such as victims of a terrorist incident, care givers in disaster relief operation, or a military unit engaged in peacekeeping operations*].)

(3) Specific support mission. (*Type of stability and support operational activity.*)

b. Location. (*This includes the location of CSC*/*MH assets and units*/*groups supported.*)

c. Attachments.

d. Coordination Requirements.

(Classification)

F-14. Sample Format for the Combat Health Logistics Portion of the Combat Health Support Plan

(Classification)

COMBAT HEALTH LOGISTICS

1. CONCEPT OF THE OPERATION (*This paragraph includes information on the SIMLM function* [*if appropriate*]*, other military or civilian Services*/*governments*/*agencies providing support, and coordination requirements*.)

2. CLASS VIII (*This includes both medical supplies*/*equipment and blood*.)

3. OPTICAL FABRICATION

4. MEDICAL EQUIPMENT MAINTENANCE

5. ABANDONED/CAPTURED MEDICAL SUPPLIES AND EQUIPMENT

6. DONATED MEDICAL SUPPLIES AND EQUIPMENT

(Classification)

APPENDIX G

NUCLEAR, BIOLOGICAL, AND CHEMICAL CONSIDERATIONS

G-1. Threat

a. The potential for the employment of NBC weaponry against a deployed US force must be considered as a condition of the battlefield by commanders at all levels. The ease of NBC employment, the difficulty of identification and treatment, and most importantly, the publicity value of even an isolated BW or CW agent attack lends itself well to stability and support operations. The use of an agent would rapidly focus international attention on the deployed US forces, their mission, training, and readiness posture to protect themselves. Further, a terrorist organization claiming responsibility for the attack would receive media attention (which is frequently their goal). In this regard, chemical agents with their historical shock value would be particularly well suited from the terrorist standpoint to gain the maximum psychological impact.

b. The ability of small organizations (especially terrorists) to either produce or procure supplies of BW and CW agents has been documented. The degree to which such agents pose a threat against a deployed US force is dependent upon the goals and objectives of the terrorist organizations. As such, the degree of the NBC threat must be developed from the standard threat indicators formula—*capabilities* + *intentions* = *threat*. This threat must be addressed as a part of the overall threat identification process. Protective procedures can be developed by the commander following this assessment. Protective measures for a commander to consider include—

- Training.
- Protection.
- Detection and identification.
- Prophylaxis.
- Contamination avoidance.
- Decontamination (patients, personnel, and materiel).

G-2. Biological Warfare Agents

a. Biological warfare agents range in spectrum from sophisticated, specifically engineered infectious microorganisms and toxins produced in modern biotechnology laboratories, to simple expedient food contaminants employed by insurgents or terrorists in stability and support operations. Gross contamination of water supplies or ingestion of adulterated foodstuffs present the most likely mode of BW agent delivery. Commonly used techniques which have been employed in stability and support operations include—

- Sharpened stakes (Punji stakes) smeared with human or animal waste. (This results in an infection in addition to the actual puncture wound.)

- Contamination of water and ice sources using infectious waste (discarded bandages or medical dressings), animal and human excreta, or carrion or remains.

- Contamination of locally procured foodstuffs with infectious organisms.

- Direct contamination of foodstuffs by locally hired cooks and food handlers sympathetic to or coerced by terrorists.

b. In considering the threat posed by BW agents, the primary means of protection available to US forces is to implement PMM. These measures include—

- Practicing personal hygiene and field sanitation (FMs 21-10 and 21-10-1).

- Maintaining a current immunization status for the AO.

- Taking prescribed prophylaxis.

- Implementing a rigorous field sanitation program incorporating water inspection by PVNTMED personnel (inspection of food for wholesomeness is the responsibility of the Veterinary Service).

- Developing a medical screening and health certification program for the hire of HN personnel, if required by medical authority.

- Implementing water discipline and sleep programs.

- Establishing a health care program to closely monitor the health of the command.

- Health care personnel must be alert to any increase in infectious disease rates or disease cases not commonly found in the AO. (The commander must be kept informed as they occur. Medical observation continues to provide the primary warning as rapid field BW agent detectors are not available.)

c. Suspected or confirmed incidents of BW agent employment are reported through the Special Telegraphic Report of Selected Diseases, RCS MED-16. Format for this report is provided in AR 40-400 and through NBC reporting procedures as outlined in FM 3-3.

d. Initial treatment of biological agent patients is based on symptomatic indicators. Refer to FM 8-9 and FM 8-10-7 for additional information.

G-3. Chemical Warfare Agents

a. Chemical warfare agents provide the terrorist with a capability to produce casualties and capture media attention as does no other single weapon at his disposal. Chemical agents are relatively easy to make and to employ; their effects are immediate and dramatic. Chemical warfare agents/weapons are used for their injury or death production mechanism, especially the well-known variety of vesicants and

nerve agents. These categories have the most potential for threatening deployed US forces. Possible means by which chemical agents can be employed include—

- Terrorist chemical attack using locally made low-strength agents.
- Water source contamination.
- Contamination of foodstuffs, to include direct contamination by locally hired cooks and food handlers.
- Chemical weapons provided through a country sympathetic to the terrorist cause.

b. Although not classed as chemical agents (weapons), incendiary/flame munitions, phosphorus compounds, and irritants (CS and CN) will most likely be encountered by US forces in stability and support operations.

c. The NBC defense is a balance of three principles—avoidance, protection, and decontamination—in order to defend against the effects of NBC weapons. These principles apply in stability and support operations as well as war. United States forces must try to avoid or limit the spread of contamination. There are fairly broad groups of activities that comprise protective measures. They are hardening positions and protecting personnel, assuming MOPP, reacting to the attack, and using collective protection. As is the case of BW agent protection, a thorough food and water sanitation/inspection program greatly reduces the possibility of a clandestine chemical assault achieving its goal. In the event of an overt chemical attack, or indirect exposure, physical protection measures and supporting equipment are readily available to the force commander for detection and protection. The keys to protecting the force are individual and unit training on basic soldier skills and leader tasks with emphasis on—

- Recognizing and reacting to NBC hazards.
- Donning, wearing, removing, and storing the protective mask.
- Decontaminating skin and personal equipment.
- Administering nerve agent antidote to self (self-aid) and to a buddy (buddy aid).
- Exchanging MOPP gear.
- Maintaining individual protective mask.
- Maintaining and putting NBC defense equipment into operation.

d. Signs, symptoms, first aid, patient decontamination, and medical treatment procedures for chemical agent casualties or military chemical injuries are provided in FM 8-9, FM 8-285, and FM 8-10-7.

G-4. Nuclear Weaponry

a. The employment of nuclear weapons in stability and support operations is not likely; however, commanders must be prepared for their use. With the advent of new technologies, it is conceivable that a terrorist or terrorist organization could obtain a small nuclear device. This device could then be used to hold a city or state at ransom. The employment of nuclear weapons could rapidly escalate a stability and support operational scenario into a major war.

b. The use of radioactive material to contaminate food and water supplies is a more likely method of employment by terrorists. Monitoring food and water is a must.

c. Food suspected of being contaminated with radioactive material must be inspected by veterinary personnel. They will determine if the food can be used as is, decontaminated then used, or whether it must be destroyed. Food containers, such as unopened cans, can be decontaminated by unit personnel. Refer to FM 8-10-7 for additional information.

d. Preventive medicine personnel will evaluate the water supply to determine if it is safe to consume.

G-5. Operations Under Nuclear, Biological, and Chemical Conditions

Operations under NBC conditions for US forces will cause additional concerns for medical units. Increased incidence of heat casualties may occur due to prolonged wearing of MOPP. An increased number of psychological casualties may also occur from personnel thinking they were exposed to CW agents. Further, if persistent blister agents are used, significant resources may be required to care for these patients. Due to slow wound healing, these injuries require a long and intensive treatment process.

G-6. Civilian Disasters

In stability and support operations, CHS personnel must also be prepared to respond to and treat victims of civilian disasters involving commercial biological research, chemical production, or nuclear power generating facilities. These facilities could be damaged due to collateral damage involving military action, accidents, damage from natural disasters (earthquakes, hurricanes), or terrorist activity. Further, the transport of chemical or nuclear weapons or materiels could potentially create a chemical/nuclear contamination situation within a civilian community due to either an accident or terrorist incident. The same triage and treatment protocols are used in these instances as are used for military NBC casualties.

APPENDIX H

SAMPLE CHECKLIST FOR DEPLOYMENT FOR COMBAT HEALTH SUPPORT OPERATIONS

H-1. General

a. This appendix provides a sample checklist that can be used in the event of mobilization or deployment. It is not to be considered all-inclusive as there may be specific procedures or requirements that are unique to the command assigned and to the operation.

b. Additional checklists for CSS operations in general are contained in FM 63-6.

H-2. Sample Predeployment Checklist

a. *Unit Operations*.

____ Are appropriate doctrinal and training literature products and procedures available?
____ Is the OPLAN current and available? (Are there any contingency plans or mass casualty plans developed or required?)
____ Are the commander's guidance, intent, and concept of the operation clearly established and available?
____ Has a medical threat update been requested and received?
____ Has the CHS planner been involved early in the planning process?
____ Are maps, overlays, aerial reconnaissance photographs, or other similar documentation of the AO available?
____ Has the CHS C2 structure been identified?
____ Have individual unit/command responsibilities been delineated?
____ Have the responsibilities been clearly stated for both supporting and supported units?
____ Have all preparation for oversea movement (POM)/preparation of replacements for oversea movement (POR) requirements been accomplished?
____ Have all OPSEC measures been taken?
____ Have language-qualified personnel been identified?
____ Are passports required? (If so, how long is required to obtain them?)
____ For domestic support operations—
    ____ Has proper authority been received for the tasking?
    ____ Have the responsibilities of the DOD component, other federal agencies, state and local governmental agencies, relief organizations, and others been clearly delineated?
    ____ Have funding sources been identified for reimbursement?
    ____ Have eligibility for care issues been addressed and a clearly stated policy established?
    ____ Has coordination for administrative/logistics support been accomplished?

____ For humanitarian assistance and disaster relief operations—
- ____ Has clear legal authority been granted for participation?
- ____ Has coordination with the country team and other appropriate services/agencies been accomplished?
- ____ Have funding sources been identified?

b. Training.

____ Has initial or refresher training been accomplished in the following areas?
- ____ Preventive medicine concerns in the AO, to include—
  - ____ Field sanitation and personal hygiene.
  - ____ Prevalence of endemic and epidemic diseases.
  - ____ Poisonous plants, wild animals, and reptiles.
  - ____ Climate and associated environmental concerns.
  - ____ Pest management.
  - ____ Personal protective measures (insect repellent, bed netting, sunscreen).
- ____ Stress control measures.
- ____ Operations, signal, and communications security.
- ____ Military occupational specialty refresher training.
- ____ Common soldier tasks refresher training.
- ____ Mass casualty situations.
- ____ First-aid refresher training for nonmedical personnel.
- ____ Instruction on litter handling and litter bearer duties for nonmedical personnel.

____ Have personnel been oriented to new AO and mission, to include—
- ____ Mission update.
- ____ Update on OPLANs, operation orders (OPORDs), or fragmentary orders (FRAGOs).
- ____ Emergency warning signals.
- ____ Threat update.
- ____ Force protection measures.
- ____ Terrorism awareness and antiterrorism measures.
- ____ Rules of engagement.
- ____ Uniform requirements and issue of specific equipment or clothing for the mission (such as extreme cold weather operations).
- ____ Local customs and mores.
- ____ Religious beliefs of the population (in many cases, there may be more than one and they may be at odds with each other).
- ____ Status of Forces agreements.
- ____ Local laws.
- ____ Personnel restrictions, curfews, and pass procedures.
- ____ Applicable international laws, agreements, or conventions.
- ____ Applicable US laws, codes, and regulatory guidance.
- ____ Languages (there may be more than one predominate language or dialect within the language).
- ____ Political considerations and dynamics in the region.

____ Location and hours of operation of support facilities, if available.
____ Climate and terrain and their potential impact on mission accomplishment.
____ Status of HN support available.

c. Concept of Combat Health Support.

____ Has mission assessment been completed?
____ Has support been tailored to the specific mission?
____ Are personnel or equipment augmentation or reinforcement required to accomplish mission?
____ Have the MESs been inspected for dated and/or missing items?
____ Are there any special equipment (pitons, piton hammers, ropes, and such) requirements?
____ Are there any specialized clothing requirements (cold weather gear, jungle fatigues)?
____ Are there requirements for chemoprophylaxis while in the AO? (If so, are appropriate medications available or requisitioned?)
____ Will the unit participate in an operation consisting of traditional force structure (medical platoon, FSMC, MSMC, corps medical units)? If not—
  ____ Is there a requirement to coordinate directly with the USAF for aeromedical evacuation support? (If so, are the appropriate DD forms on hand? Has a liaison been appointed?) (Refer to FM 8-10-6.)
  ____ Is there a requirement to coordinate directly with the USN for hospital ship support? If so—
    ____ Are medical evacuation pilots deck-landing qualified?
    ____ Is communications equipment interoperable?
    ____ How will CHL (to include blood) be obtained?
____ Are there any special storage requirements?
____ Will automated reporting systems be used (Theater Army Medical Management Information System [TAMMIS])? If so—
  ____ Are equipment and software on hand?
  ____ Are there any special coordination requirements to support the equipment?
____ Does this mission involve a multinational force? If so—
  ____ What are the endemic diseases of each participating country?
  ____ Is the US responsible for CHS for the other nations' forces?
____ What is the composition of the population to be supported?
  ____ Healthy soldiers in a combat-related role or a cross-section of the civilian community from infants to geriatrics?
  ____ If infant and geriatric patients are anticipated, are MESs augmented with appropriate medications and equipment to treat these patients?
____ What support can the HN provide? Are contracting personnel available to negotiate support requirements?
____ Are veterinary personnel available for the inspection of locally procured foodstuffs?
____ Are PVNTMED personnel available to inspect water and ice sources for potability?

____ Is there a possibility that PVNTMED support will be required for temporary camps established for displaced persons or refugees? If so—
  ____ What effect will it have on the provision of PMM to supported troops?
  ____ What is the status of PVNTMED supplies to support the additional mission?
____ Will PVNTMED assets require augmentation?
  ____ Is support to refugees anticipated?
  ____ Is support to EPW and/or detainees anticipated?

APPENDIX I

SPECIALTY RESPONSE TEAMS

I-1. General

This appendix contains brief descriptions of SRTs. These teams provide a rapidly available asset to compliment the need to cover the full spectrum of military medical response locally, nationally, and internationally. These teams are organized by USAMEDCOM subordinate commands; they are not intended to supplant TOE units assigned to Forces Command or other major commands. The regional medical commands (RMCs), USACHPPM, US Army Medical Research and Materiel Command (USAMRMC), and US Army Veterinary Command (USAVETCOM) commanders organize SRTs using their tables of distribution and allowances (TDA) assets. These teams enable the commander to field standardized modules in each of the SRT areas to meet the requirements of the mission.

I-2. Responsibilities

a. As stated above, the SRTs will be standardized and formalized within the TDA assets of the USAMEDCOM subordinate commands.

(1) Each RMC will be responsible for organizing and fielding a Chemical/Biological (Chem/Bio) SRT, a Trauma/Critical Care SRT, a Stress Management SRT, and a Telemedicine SRT.

(2) The USAMRMC's US Army Institute of Surgical Research (USAISR) will organize and resource the Burn SRT.

(3) The USACHPPM will organize and field three PVNTMED Threat Assessment SRTs.

(4) The USAVETCOM will organize and field four Food Safety, Veterinary PVNTMED, and Animal Health Care SRTs.

b. One or more teams may be deployed on a specific mission. The senior medical person deployed (unless otherwise designated) provides the CHS C2 required. He is also responsible for coordinating the teams' effort for mission accomplishment.

I-3. Requests for Assistance

a. Requests for assistance may be generated from numerous sources. These sources may include—

- Supported military forces within the RMC or abroad.
- Local communities within the geographical boundaries of the RMCs.
- Federal agencies through the DOD.
- Foreign nations through the DOS.

b. Regardless of the point of origin, all requests for assistance from USAMEDCOM assets must be coordinated through the USAMEDCOM headquarters.

c. For additional information on requests for assistance in domestic support operations, refer to paragraph 3-3. For additional information on interagency operations refer to Appendix B.

I-4. Team Composition and Specialty-Specific Equipment

a. The USAMEDCOM will determine the composition of each team and will identify the specialty-specific equipment required to accomplish the mission. This information will be provided to its subordinate commands through appropriate command policy statements, directives, or SOP.

b. These teams may be comprised of active duty military or DOD civilians as determined by the commander.

NOTE

When civilian personnel are included on these teams, coordination with the servicing civilian personnel office is required.

c. Personnel identified for deployment into a TOE position through the Professional Officer Filler System program will not be selected for SRT duties.

d. Members of the US Army Reserve (USAR) may be relied upon to provide a variety of functions in support of the various SRT missions. Some members of the USAR may be required to augment RMCs where certain specialties are identified as integral parts of the SRTs. As personnel in those specialties deploy in support of an SRT mission, USAR personnel may fill their vacancies.

I-5. Deployability and Continuous Operations

a. All SRTs will be capable of deploying within 18 hours of notification except for the Burn SRTs which deploys within 2 hours of notification and the Food Safety, Veterinary PVNTMED, and Animal Health Care SRT within 8 hours.

b. Team members must maintain their readiness status to deploy.

(1) All applicable immunizations must be current and complete, as decided by local travel medicine experts. Regardless of where these events occur, disease vectors will flourish and expose team members to possible infection.

(2) Dental care should be maintained to reduce the possibility of serious dental emergencies while deployed.

c. The teams will deploy in the most expeditious manner available (as deemed by the commander), either by commercial or government aircraft or vehicle. The Burn SRT is normally the only team with a dedicated medical evacuation aircraft at their disposal.

d. Team members should obtain an official US passport. Upon notification of deployment, coordination for appropriate country clearances should be accomplished.

e. The SRTs are not capable of 24-hour continuous operations. To conduct continuous operations the deployed SRTs require augmentation/reinforcement of both personnel and materiel or support from follow-on medical specialty personnel.

I-6. Administrative Support and Requirements

a. The administrative support requirements for these teams will vary depending upon the type of mission, geographic location, magnitude of the disaster/incident, and the anticipated duration of the operation. As discussed in Appendix K, if these teams are deployed to a major disaster area, they should be prepared to provide their administrative/clerical materials and perform those clerical duties themselves.

(1) Coordination for billeting, feeding, and transportation must be accomplished prior to departure. The team may not be able to stay in the immediate area of the disaster/incident and may have to commute from an area adjacent to the site. Teams deploying into disaster sites should bring sufficient MREs for the anticipated duration of the operation if they cannot confirm that other support is available.

(2) It is essential that the teams provide their own communications capability (commercial hand-held radios or cellular telephones may suffice). Once in the disaster/incident area, links with other communications systems (telephone, FM radios, or satellite) may be required to accomplish the mission. The SRTs may employ any of the following communications: cellular telephones, laptop notebooks with modems, local telephone services, local area networks, long-haul telephone services, Internet systems, military FM radios, and telemedicine systems (audio, video, interactive video, and satellite).

(3) Requirements for expendable supplies are dependent upon the type and duration of the operation, anticipated level of CHL and general supply support in the AO, and availability of local resources.

b. The uniform for the teams is scenario driven. Normally, the battle dress uniform and appropriate civilian (or military) attire for DOD civilians is required. However, in some instances assuming a low profile may be desired. Guidance on dress requirements will be provided when the SRT is mobilized. Team members should have their table of allowances-50 and NBC personal protective equipment readily available and in working order. Information on any other special clothing/equipment based on the specific mission, location, season, and climate in the AO will be provided upon notification.

I-7. Equipment

As stated in paragraph I-4 above, equipment requirements for each team will be determined by USAMEDCOM and disseminated to its subordinate commands. General considerations for equipment requirements include the following:

a. All equipment to support the team must be deployed with the team, either as carry-on or checked baggage. Additional costs may be incurred if the equipment exceeds the allowable weight or number of containers.

b. The parent command is responsible for preparing and distributing any CHL resupply packages required for the support of the deployed teams.

c. All medical equipment that will be used on a USAF aircraft must have the appropriate air worthiness certification.

d. If the teams are deploying to an overseas area, appropriate country clearances may be required before equipment and supplies (such as pharmaceuticals and chemicals) can enter the HN. Further, the team must ensure that they have the required regulatory clearances to transport any chemicals, medical gases, or other materials with restrictions aboard the aircraft.

e. Teams must deploy with all individual/unit PVNTMED measures and field sanitation equipment.

I-8. Training

a. Those personnel selected to comprise the SRTs should receive training and orientation in areas of general interest for conducting these operations. Topics may include—

- Humanitarian assistance operations.
- Media relations training.
- Interagency operations.
- Domestic support operations.
- The role of governmental and nongovernmental agencies in disaster relief.
- The role of the FEMA.
- The NDMS.
- Emergency medical treatment and/or first aid (for nonmedical personnel).
- Multinational operations.

- Social, political, economic, and religious information on the local populace in the AO.
- Team field sanitation training and unit/individual PVNTMED measures (FMs 21-10 and 21-10-1).

b. Professional training requirements are discussed under each specific type of SRT.

c. One of the keys to teamwork is practice. To enhance the effectiveness and efficiency of the SRT, the team should conduct rehearsals at least quarterly. Assessing and evaluating the outcome of these rehearsals provides the team an opportunity to strengthen their skills and teamwork.

d. When possible, training opportunities with local, national, and international agencies and organizations should be pursued. This interaction is crucial to refining procedures, enhancing coordination, and facilitating the integration of the SRTs into the relief efforts.

e. After a deployment, the team should conduct an after-action debriefing to identify those areas requiring additional refinement.

I-9. Trauma/Critical Care Specialty Response Team

a. The Trauma/Critical Care SRT is capable of providing technical expertise to local first responders in the areas of triage, assessment, and advanced trauma management of mass casualties with severely injured casualties. When required, it may also assist in providing direct patient care using existing on-site resources and facilities on-site. Further, this team can assess what follow-on specialty skills are required to enhance the care of the victims, provide guidance to the management staff on trauma/critical care requirements, and provide consultation to other health professionals at the incident site.

b. The qualifications for this team are that the providers be ATM trained, maintain current standards for deployability, and receive continuing medical education in trauma care on a yearly bases.

I-10. Burn Specialty Response Team

a. The Burn SRT is capable of deploying worldwide within 2 hours following notification. This team receives, triages (multiple patients), and provides resuscitative treatment to burn patients. Further, the team can evacuate one to five burn patients to the USAISR located at Brooke Army Medical Center, Fort Sam Houston, Texas. During evacuation, the Burn SRT provides en route medical care to sustain the patient during transport.

b. The personnel comprising the team are all flight-qualified on fixed-wing medical evacuation aircraft. Further, equipment requirements may change depending upon the actual scenario. If the team's mission is to stay at the location of the incident/disaster and treat, additional medical supplies will be required.

c. The Burn SRT is deployed on a military aircraft that remains at the incident site and is used to evacuate the burn patients to the USAISR burn unit. If the mission of the team is to stay at the incident site

and treat the patients on-site, coordination for the return aircraft is required.

d. The personnel comprising the Burn SRT should be trained and experienced in the treatment of burn patients. Physicians should receive training in Advanced Burn Life Support (ABLS), Advanced Trauma Life Support, Advanced Cardiac Life Support (ACLS), and Pediatric Advanced Life Support. Nonphysician members require 1 year of USAISR experience, ABLS, and ACLS. All members should attend the flight physiology course conducted at Brooks Air Force Base, Texas.

I-11. Preventive Medicine Threat Assessment Specialty Response Team

a. The mission of this SRT is to provide initial disease and environmental health threat assessments. This is accomplished prior to or in the initial stages of a contingency operation, or during the early or continuing assistance stages of a disaster.

b. Although the basic SRT is standardized, the PVNTMED Threat Assessment SRT may be tailored to the requirements of the specific mission if the Commander, USAMEDCOM determines additional specialties are needed. It can—

- Perform on-site initial health threat assessments, limited and rapid hazard sampling, monitoring, and analysis, health risk characterization, and needs assessment for follow-on PVNTMED specialty or other medical treatment support in the AO.
- Prepare PVNTMED estimates.
- Perform analysis of, but not limited to—
  - Endemic and epidemic disease indicators within the AO.
  - Environmental toxins related to laboratories, production and manufacturing facilities, nuclear reactors, or other industrial operations.
  - Potential NBC hazards.
- Provide medical threat information and characterize the health risk to deployed forces or civilian populations.
- Provide guidance to local health authorities on surveying, monitoring, evaluating, and controlling health hazards relative to naturally occurring and man-made disasters.
- Assist local health authorities in surveying, monitoring, evaluating, and controlling health hazards relative to naturally occurring and man-made disasters.

c. The composition of the PVNTMED Threat Assessment SRT will be determined by the specific mission and guidance provided by the USAMEDCOM. The team may—

- Request information from the AFMIC, WHO, and other agencies with endemic disease and environmental effects information to prepare their database for the AO.

- Request information from the Centers for Disease Control (in the event of a national disaster) to establish a baseline for determining the effects/impact of the disaster.

- Determine the need for follow-on medical specialty teams or PVNTMED detachments to definitively characterize the operational force health risks associated with domestic disaster emergencies, foreign deployments, or other contingency operations.

- Elect to use telemedicine reach back, or request assistance from appropriate domestic, foreign, or international response assets after the initial assessment is completed.

d. In addition to the general orientation and training discussed in paragraph I-8, the PVNTMED Threat Assessment SRT should be cross-trained in the fields of—

- Engineering.

- Environmental science.

- Preventive medicine.

- Infectious and communicable diseases.

- Industrial hygiene.

- Nuclear medical science.

- Entomology.

- Animal health, food safety, and veterinary PVNTMED.

- Database management.

- Medical information/public health planning.

I-12. Chemical/Biological Specialty Response Team

a. The Chem/Bio SRTs include the following USAMEDCOM staffed assets: The National Medical Chem-Bio Advisory Team (MCBAT) at the USAMRMC and the RMC Chem/Bio SRTs. The National MCBAT is comprised of USAMRMC elements from the US Army Medical Research Institute of Infectious Diseases (USAMRIID) and the US Army Medical Research Institute of Chemical Defense. These assets are Tier 1 elements of the DOD Chemical Biological Quick Response Force (CBQRF) and are

ready to deploy worldwide within 4 hours after receiving their orders. The Chem/Bio SRTs are trained medical teams located at the RMCs that can deploy in response to a chemical, biological, or radiological incident.

b. Examples of incidents which may require a rapid response include—

- An accident involving the transport or storage of NBC weapons.
- The release of CW or BW agents or radiological material.
- A leak of an industrial chemical, infectious material, or radioactive material.

c. The National MCBAT is the principal DOD medical advisor to the Commander, CBQRF and the Interagency Response Task Force. Both the National MCBAT and regional Chem/Bio SRT can provide medical advice and consultation to commanders or local medical and political authorities for preparation of a response to a threat or actual incident. They can also provide medical advice to commanders or local authorities on protection of first responders and other health care personnel, casualty decontamination procedures, first aid (for nonmedical personnel) and initial medical treatment, and casualty handling. The initial advice includes signs, symptoms, first aid (self-aid, buddy aid, combat lifesaver aid for military personnel), and initial treatment when an incident has occurred. It also assists in facilitating the procurement of needed resources. During an incident response, all response personnel must first protect themselves from the agent/material, then provide response assistance to victims.

d. The Chem/Bio SRT will conduct the initial response, and upon arriving at the incident site or AO, will determine the types and number of other responders required. The RMC Chem/Bio SRT may, after initial assessment of the situation, elect to use telemedicine reach back or to call in domestic or foreign response assets organized at the national level. These response assets include the National MCBAT and the Aeromedical Isolation Team (AIT) from USAMRIID. The AIT is a highly specialized medical evacuation asset for the evacuation of limited numbers of contagious casualties with lethal infectious diseases, or for consultation on appropriate management of such casualties in place in the event of a mass casualty situation.

I-13. Stress Management Specialty Response Team

a. The mission of this Stress Management SRT is to provide initial NP, mental health, and stress assessment prior to or in the initial stages of an incident/event. The Stress Management SRT may provide initial, limited NP triage and stabilization for a small number of clinical cases. This team may provide initial critical events stress management for the military and civilian responders and for survivors as directed.

b. The precedent of using stress management teams has been established. Within the past few years, numerous accidents and hostile incidents have demonstrated the value of crisis stress control for soldiers, their families, and civilians caught in the turmoil of peacetime operations. Unit leaders, aided by post and hospital mental health personnel, chaplains, and others, played a key role in providing crisis stress control for many of these tragic incidents. In the peacetime military, as in civilian police, fire, and disaster relief, stress debriefing of critical incidents has proven its value in sustaining mission performance and in

reducing disabling post-traumatic stress disorders.

c. Capabilities of the Stress Management SRT include—

- Providing initial assessment of stressors, stress responses, and psychological trauma issues.
- Identifying and categorizing populations at risk.
- Providing initial assessment of stress and mental health requirements.
- Advising commanders or local authorities on mental health and stress issues.
- Providing critical event stress management, to include group defusing/debriefings and individual counseling.
- Conducting surveys and interviews, asking questions, and identifying cases for further counseling and treatment.
- Advising or augmenting MTFs to enhance their mental health and stress management capabilities.
- Coordinating for additional mental health/stress management resources as required.

d. The Stress Management SRT must be prepared to provide stress management for multiple types of contingency operations. All members should complete a critical events management course. At least two of the professional staff members should have expertise in child/adolescent development and mental health. Subject areas where training could be of value include—

- Victims' assistance.
- Psychological trauma.
- Post-traumatic stress disorders.
- Types of mental health problems following disasters.
- Special risk groups.
- "Burnout" Syndrome pertaining to human services and disaster relief workers.
- Ethics of interviewing (confidentiality and privacy).
- Effects of chemical/biological/radiation exposure and their differential diagnosis and

treatment.

I-14. Telemedicine Specialty Response Team

The Telemedicine SRT provides the vital communications link for the other deployed SRTs to interface with the parent MEDCEN and other activities, as required. By leveraging technology, the telemedicine SRT enables the deployed health care providers and other health professionals to consult closely with specialists at the home station or elsewhere.

a. The electronic bridge the Telemedicine SRT establishes between the deployed SRTs and the supporting MEDCEN and other activities allows the interchange of health information and results in an enhanced ability to—

- Rapidly and accurately diagnosis disease and injury.
- Promptly determine appropriate treatment regimes.
- Monitor the patient's medical condition.
- Rapidly transmit and receive real-time medical threat data and facilitate its analysis into medical intelligence.
- Expedite notification of other CHS teams required to deploy in response to the disaster/ incident after initial assessment is completed and requirements are identified by the deployed SRTs.

b. The size and capability of the telemedicine SRT will be scenario driven and will depend upon the number of SRTs deployed, the type of mission, the anticipated duration of the operation, and the type and quantity of equipment deployed.

c. To maximize the interoperability between the deployed teams and the supporting facilities and agencies, the equipment used will be that which is currently available and compatible. This equipment will be updated when newer state-of-the-art medical information systems (hardware and software) become available and efforts will be made to standardize these systems throughout the AMEDD and Army tactical systems.

d. As the resources of the Telemedicine SRT will be constrained, prioritization of support requirements must be accomplished. The Telemedicine SRT provides a distributed voice system, a video teleconferencing system, digital imaging systems, information systems, and local area network with selective access to wide area networks. This includes integrated software to support PVNTMED, logistics, decision support, and when required, health provider input to the patient digitized clinical record and patient administration.

e. Services that will be essential to the accomplishment of the Telemedicine SRT mission include—

- Voice. The voice requirements of the SRT include internal, on-site communications for command, control, and coordination.

- Data. The Telemedicine SRT will depend upon the use of inexpensive, global, two-way messaging. Most consultation applications can be accomplished using *store and forward technologies* and communications systems.

- Reach-back services. As requirements change during the mission, the reach-back services required will include video teleconferencing; electronic mail; voice; imagery file transfer; wide area network; and possibly paging.

- Bandwidth requirements. Bandwidth on demand will offer the best possibility for low cost and small telecommunications support.

I-15. Food Safety, Veterinary Preventive Medicine, and Animal Health Care Specialty Response Team

a. The mission of the Food Safety, Veterinary PVNTMED, and Animal Health Care SRT is to assess the degree of existing destruction and/or impending risk and to determine recommended follow-on actions relative to animal health and food safety. The SRT also—

- Advises local first responders on food safety/veterinary PVNTMED issues.

- Advises local first responders on triage and treatment of injured animals.

- Provides limited triage and emergency treatment of injured animals including lifesaving emergency procedures, or when appropriate, euthanasia to prevent undue suffering of those cases encountered during the assessment process.

- Provides veterinary care for military search and rescue dogs; when authorized, it also provides care to other governmental and nongovernmental agencies' animals participating in the operation.

b. The Food Safety, Veterinary PVNTMED, and Animal Health Care SRT can—

- Assess food contamination and potential for foodborne illness outbreaks.

- Determine the magnitude of animal involvement in public health and zoonotic disease threat.

- Make initial assessment and recommend corrective actions.

- Provide liaison with follow-up relief organizations/agencies.

- Assist in establishing control for the AO.

- Coordinate with all known animal medicine/food safety agencies and organizations in the AO.

c. The Food Safety, Veterinary PVNTMED, and Animal Health Care SRT must be highly trained and prepared to provide veterinary services for multiple types of contingency operations. All members should maintain proficiency in their area of concentration or MOS. All team members should have media relations training. Specific subject areas where training could be of value include—

- Survivors assistance.
- United States Department of Agriculture courses.
- American Veterinary Medical Association sponsored courses.
- Emergency medical treatment.
- Nuclear, biological, and chemical incidents (to include NBC threat information; working in a contaminated environment; and decontamination and treatment of NBC contaminated animals).

APPENDIX J

MASS CASUALTY SITUATIONS

J-1. General

Mass casualty situations occur when the number of casualties exceeds the available medical capability to rapidly treat and evacuate them. In disaster relief operations and in the aftermath of terrorist incidents, mass casualty situations frequently occur. For example, a disaster that destroys a significant amount of property may result in a mass casualty situation even though the number of injured is relatively low. By destroying a significant number of the medical assets within the community, those injured cannot obtain care locally and, therefore, overwhelm the remaining medical assets.

J-2. Mass Casualty Management

Mass casualty situations are normally chaotic—

- Victims are in various stages of pain and distress.
- Casualties may have single or multiple injuries, or may have conventional injuries which are complicated by NBC exposure (such as in a toxic spill or nuclear power plant accident).
- Casualties will range in age from infants to geriatric patients. Parents and loved ones may not want to be separated from the victim, even to permit the provision of medical care.
- Severity of medical conditions will vary from relatively minor injuries to severe, life-threatening trauma. Medical care provided may be complicated due to pre-existing medical conditions (disease, injury, or disability).
- New casualties will be arriving before the patients already on hand are treated.
- There may be personnel who are just dazed and wandering throughout the area disrupting operations.
- There may be uninjured persons looking for a family member, friend, or coworker; their search may be disruptive to the ongoing medical operation.

a. *Planning*. To ensure efficient management of mass casualty situations, the CHS planner must develop an effective plan and then rehearse it on a periodic schedule.

(1) In mass casualty situations, medical resources are scarce. The plan, therefore, must be comprehensive and efficiently use what medical resources are available.

(2) Planning considerations include—

- Establishing a control element to coordinate ongoing activities and release information updates.

- Securing the area and limiting access to nonessential personnel.
- Establishing communications between areas within the facility or treatment areas.
- Establishing the triage, treatment, and holding areas.
- Establishing a traffic pattern that provides for the smooth flow of patients and vehicles.
- Marking routes to the different areas.
- Orienting all personnel (medical and nonmedical) operating the mass casualty station to the types of markings used, layout, and routes to be followed.
- Organizing medical personnel for staffing of the different areas.
- Organizing nonmedical personnel (such as from relief organizations) and volunteers for litter bearer duties, as messengers, for restocking supplies, and for other nonmedical functions.
- Ensuring an adequate blood supply and/or other Class VIII items are available or on order.
- Providing timely evacuation.

b. Rehearsal and Training.

(1) The response to a mass casualty situation must be rehearsed. By conducting rehearsals, unit personnel become familiar with where they should report and with what their duties should entail.

(2) Nonmedical personnel assigned to the unit should be trained in the proper techniques for loading, carrying, and unloading litters. This training will enhance their ability to perform the task by reducing fatigue and risk of injury from transporting patients incorrectly. (Refer to FM 8-10-6 for additional information.)

(3) In disaster relief operations, in response to terrorist incidents or in other mass casualty situations, the military unit may not be operating alone, but rather in conjunction with other relief agencies, humanitarian assistance organizations, and religious groups. Even though there would not be time to rehearse a mass casualty plan with the other agencies/organizations involved, the medical unit can rehearse a response to a typical mass casualty situation. This rehearsal will allow them to function more effectively and more easily incorporate and adapt to changes in the actual scenario.

J-3. Triage Categories

Triage is the medical sorting of patients according to the type and seriousness of injury, the likelihood of survival, and the establishment of priorities for treatment and evacuation. Triage ensures that medical

resources are used to provide care for the greatest benefit to the largest number of injured. Ideally, sufficient medical assets will be deployed to the operational site so that all victims can receive the required care in a timely manner. However, in the time immediately following the incident, this may not be possible. The triage process, therefore, is required.

a. Triage (or sorting) is the process of prioritizing or rank ordering trauma victims on the basis of their individual needs for surgical intervention. The likely outcome of the individual victim must be factored into the decision process prior to the commitment of limited medical resources. Victims are generally sorted into four categories (or priorities). These priority groupings are discussed in decreasing order of surgical urgency.

b The four categories of the triage of conventional injuries are—

(1) *IMMEDIATE*. This category is for the patient whose condition demands immediate, resuscitative treatment. An example of this treatment is the control of hemorrhage from an extremity. Generally, the procedures used are short in duration and economical in terms of medical resources.

(2) *DELAYED*. Victims in the DELAYED category can tolerate delay prior to operative intervention without unduly compromising the likelihood of a successful outcome. When medical resources are overwhelmed, victims in this category are held until the IMMEDIATE cases are cared for. An example is stable abdominal injuries with probable visceral involvement, but no significant hemorrhage. These cases may go unoperated for 8 to 10 hours, after which there is a direct relationship between time lapsed and the advent of complications. Other examples include—

- Soft tissue injuries requiring debridement.
- Maxillofacial injuries without airway compromise.
- Vascular injuries with adequate collateral circulation.
- Genitourinary tract disruption.
- Fractures requiring operative manipulation, debridement, and external fixation.
- Eye and central nervous system injuries.

(3) *MINIMAL (or AMBULATORY)*. This category is comprised of victims with injuries that are so superficial that they require no more than cleansing, minimal debridement under local anesthesia, administration of tetanus toxoid, and first-aid type dressings. They must be rapidly directed away from the triage area to uncongested areas where first aid is available. Examples include burns of less than 15 percent of the total body surface area (TBSA), with the exception of those involving the face, hands, and genitalia. Other examples include—

- Upper extremity fractures.

- Sprains.
- Abrasions.
- Behavioral disorders or other obvious psychiatric disturbances.

(4) *EXPECTANT*. Victims in the EXPECTANT category have injuries that are so extensive that even if they were the sole casualty and had the benefit of optimal medical resources application, their survival would be very unlikely. During a mass casualty situation, this sort of patient would require an unjustifiable expenditure of limited resources that are more wisely applied to several other more salvageable victims. The EXPECTANT patients should be separated from the view of other victims; however, they should not be abandoned. Above all, one attempts to make them comfortable by whatever means necessary and provides attendance by a minimal but competent staff. Examples of this category include—

- Unresponsive patients with penetrating head injuries.
- High spinal cord injuries.
- Second- and third-degree burns in excess of 60 percent TBSA.
- Profound shock with multiple injuries.
- Agonal respiration.

J-4. Control Element

The key to the management of a mass casualty situation is control. To enhance the effectiveness of mass casualty operations, an on-site control element must be established to coordinate the various aspects of the support.

a. The treatment facility director (or if an MTF is working independently of other relief organizations, the MTF commander) designates the individuals who will staff the control element. This element is responsible for—

- Implementing the plan.
- Establishing security.
- Limiting access to the area.
- Monitoring ongoing activities.
- Providing informational updates as required.

b. Communications with the triage, treatment, and holding areas are essential to accomplish the coordination and control of ongoing activities. If telephone/radio communications are not available, a messenger system is employed using some of the volunteers or ambulatory patients for this function.

J-5. Establishing Triage, Treatment, and Holding Areas

Depending on the location of the mass casualty, the triage, treatment, and holding areas may be established in an existing hospital or clinic, an available shelter or field unit, or outdoors.

a. Using an Existing Hospital or Clinic.

(1) When an existing hospital or clinic is used, the triage area should afford easy access for incoming litter bearer teams, ground and air ambulances and other emergency vehicles, and nonmedical transportation assets (such as privately owned cars or company trucks). Sufficient space must be allocated for ambulance and ground vehicle turnaround to ensure a smooth traffic flow. Further, space is required for helicopter landing zones (LZs). Helicopter LZs must be available when planning or using an existing facility. Wire hazards and other obstructions must be considered when establishing safe LZs. These requirements are normally met with the established layout of hospital emergency rooms; however, some clinics may not normally receive patients transported by emergency vehicles (such as when established in an office building) and depending upon the number of victims being received, additional space may be required to accommodate the patient flow. Litter stands should be established (such as sawhorses supporting litters [when commercial equipment is not available]) for placing patients to be triaged. At a minimum, two should be established with the triage officer between the stations. Resuscitation and vascular volume replacement is initiated in the triage area, if required. The flow of the injured into the triage area must be controlled. An increase in the noise level and confusion can result if too many victims are brought into the triage area at one time. These factors can adversely impact on the ability of the medical personnel to thoroughly evaluate and prioritize each victim.

(2) Specific areas within the facility are designated for each of the triage categories, personnel pools, and control element. Additionally, internal traffic routes to the x-ray, laboratory, preoperative, recovery, and holding areas must be identified.

- Ideally, holding areas for each of the four triage categories should be established. Each area should be clearly identified and the route to that area marked. Marking can be accomplished with the use of different colored panels or a numbering system. Each area can be designated as a specific color or number and the route to that area marked accordingly. The marking system used should function during times of good and limited visibility (such as at night or during power shortages). Materials used for marking purposes should be prepared when the mass casualty plan is developed and stored until required for use. The materials should not be made to rely on the knowledge of a specific language, such as English, as they may be required to be used in an area where English is not the predominant language (that is why colors and numbers are more effective).

- Two personnel pool areas should be designated; one for medical personnel and one for nonmedical personnel. The facility director should designate those individuals who will supervise the

management of these pools. As personnel complete tasks, shifts, or other duties, they report back to the appropriate personnel pool area. Using this system, ensures the efficient use of available resources and permits the reallocation of resources as requirements change. MINIMAL category patients can be used as an additional manpower pool while awaiting transportation or housing arrangements. They can act as runners, litter bearers, or guides, with minimal training or briefing, to free up medical personnel so they can attend to medical tasks.

- The control element should have access to all areas as required.

- The internal communications system should be modified as required to provide communications capability to the major areas within the facility; or, if a system does not exist, a messenger system is established.

(3) A sample layout of a mass casualty station is provided in Figure J-1. Space should be planned for and an area established for the decontamination of patients, if required. This sample is a field medical company which includes surgical augmentation. Each mass casualty situation will be unique as to the number and types of casualties, the medical facilities available, and the medical resources available to treat them. This mass casualty station should be modified to fit the realities of a specific mass casualty situation.

b. Using an Available Structure or Field Medical Unit. A mass casualty situation may occur in an area away from an established hospital or clinic, or in an area where the facility has been destroyed. It may not be practical or possible to evacuate or transport the victims to a hospital or clinic outside of the disaster site. If a structure, not previously used for a hospital or clinic, is available and safe for occupancy, it may be used. The requirements for the establishment of the area are the same as when an existing hospital or clinic is used; however, the actual layout will differ depending on the structure used. Caution must be used to develop a traffic pattern which will avoid congestion and the crisscrossing of internal paths and will expedite patient flow. Another option is to establish a field medical unit (such as a FSMC) in the vicinity of the disaster area and use it as the treatment facility.

c. Establishing the Mass Casualty Station Outdoors. In some instances, a mass casualty station may be required to be established outdoors; this is especially true in the aftermath of severe earthquakes where the stability of remaining structures has been compromised, or when significant aftershocks are occurring. When this occurs, efficient use of available shade and, if safe, overhead cover is essential. Unless inclement weather occurs, the triage area and the MINIMAL treatment area remain outdoors. The triage area must be accessible to incoming vehicles and provide sufficient space for the turnaround of the vehicles. Also, it should not be established too far away from the treatment areas, as the distance will place an additional burden on the litter bearers. Once triaged, patients should be brought inside an improvised shelter as soon as possible. The use of improvised shelters or the use of cover (such as caves) may be required until more appropriate shelters can be obtained or established.

J-6. Medical Evacuation

When mass casualty situations occur, the number of victims will normally overwhelm the available emergency vehicles and ambulances. Therefore, the mass casualty plan should include considerations for

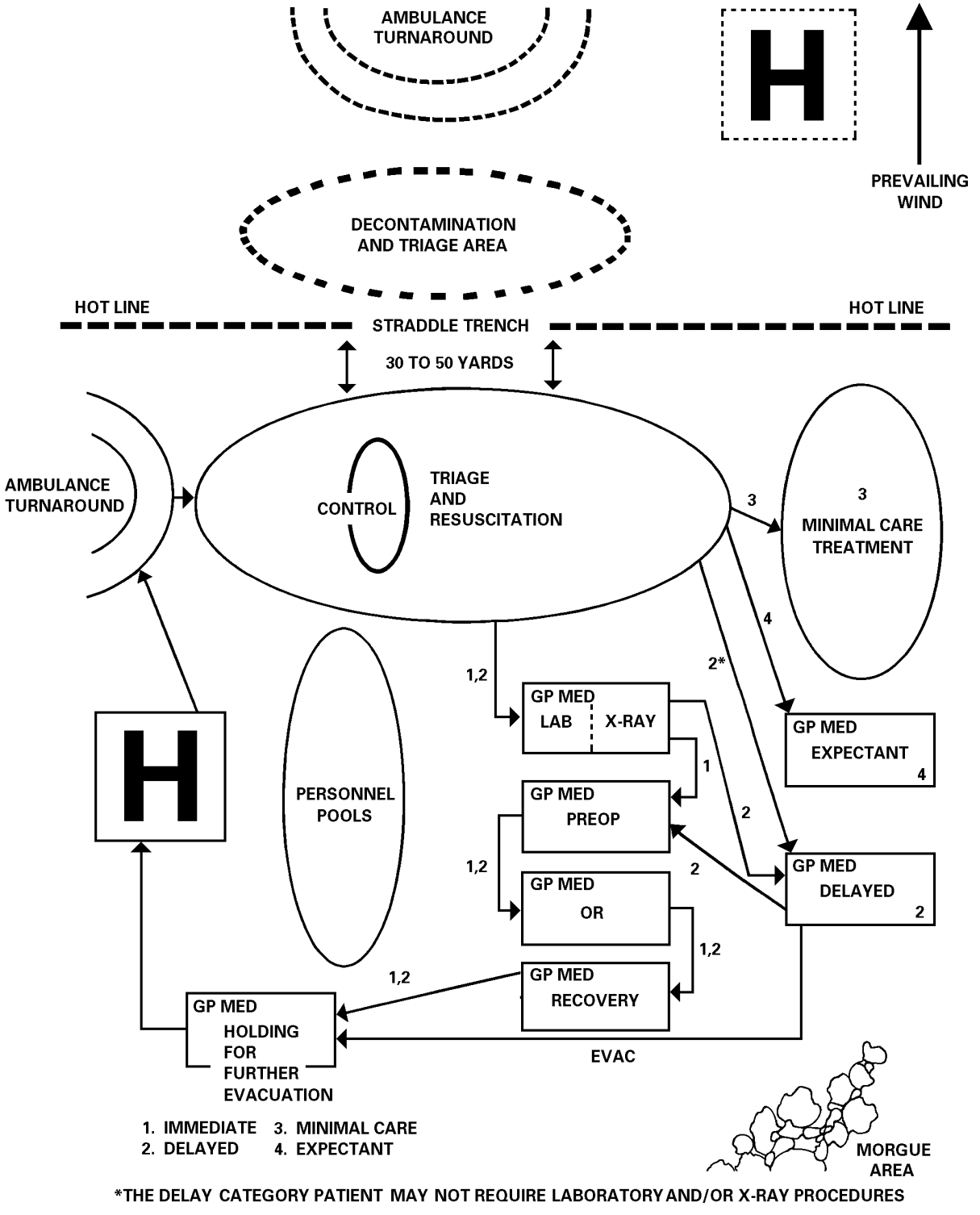


Figure J-1. Mass casualty station with triage and MINIMAL care areas established outdoors.

the use of nonmedical vehicles and aircraft (such as from religious groups, volunteer organizations, and community businesses). When at all possible, the victims who have sustained the more severe wounds should be evacuated in ground and air ambulances or emergency vehicles. These patients will benefit most from the provision of en route medical care. The more lightly injured and stable victims and those suffering from stress can be transported by nonmedical/nonemergency transportation assets without serious risk of worsening their medical prognosis.

J-7. Disposition of Remains

In a mass casualty situation, there will be victims who have died before reaching the triage area (dead on arrival) or who die of injuries before they can be stabilized and further evacuated. A temporary morgue area should be established away from and out of sight of the triage and treatment areas. If the mass casualty station is established outside, this area could be established behind a natural barrier such as a stand of trees or it can be set off by using tentage or tarpaulins. This area is not an actual morgue as it does not have the required equipment. The holding area requires minimal staffing for security. Remains are identified and transferred to mortuary facilities as soon as possible.

APPENDIX K

UNITED STATES DISASTER ASSISTANCE OPERATIONS

K-1. General

a. During disaster assistance operations, it is important that the CHS response be rapid, well planned, and thoroughly coordinated. This is accomplished by the development of contingency plans, a thorough understanding of the FRP and its delineation of duties and responsibilities, and the rapid assessment of the health care requirements precipitated by the disaster.

b. In these operations, other government agencies may have the lead. An understanding of the command/coordination arrangements is necessary at all levels to gain unity of effort and to avoid unnecessary and counterproductive friction.

K-2. Administrative Support

a. To facilitate the management of personnel and resources flooding into the disaster area, it is essential to establish a central point of administration as soon as possible within the disaster area. Once the JTF surgeon has been designated and his staff established, the administrative unit is activated. The headquarters establishing this administrative unit is responsible for preparing an SOP for the operation. This SOP prescribes formats, reports, submission requirements, and the other myriad of administrative details required to enhance the management of the operation. As the force deployed may be joint in nature, or may come from a number of different types of units, such as Active Component, US Army Reserves, or National Guard, a common reporting system will not exist. One must be established for all relief elements to use.

b. A common communications system among the various units/forces deployed must be established early on if effective C2 and administrative functions are to be successful. A system which is not accessible to a portion of the forces deployed will detract from the overall relief effort.

c. All units, whether administrative or operational, must provide for their own administrative and logistical needs. This includes such items as notebooks, paper, pencils/pens, automated equipment (laptop computers, facsimile machines), typewriters, and such. The local community in the disaster area will not be able to provide this support.

d. When small teams are deployed, they must thoroughly coordinate support for lodging and feeding prior to their deployment. The team cannot assume that it will be able to stay in undamaged motels/hotels in the disaster or outlying areas. They must be prepared to sleep and eat in a field environment.

K-3. Priorities of Support

a. In the initial phase of a disaster assistance operation, the priority of support goes to the rescue, treatment, and evacuation of the disaster victims, to PVNTMED (to include water) concerns, and to food quality and safety assurance.

- Military evacuation assets (especially helicopters) used to augment civilian capabilities should be carefully deployed to ensure that adequate coverage of the disaster area is effected. Ground evacuation assets should be employed where the road network is still intact and not blocked by debris or rubble. The aeromedical evacuation capability should be used in areas inaccessible by road; or where the criticality of the injury dictates evacuation by air. Existing medical facilities with sustained damage may be used after they have been inspected to ensure they are structurally sound. Aid station and clearing station operations can be established in areas where medical assistance is required but the existing medical facilities are not capable of providing the required support. In addition to independent operations, military medical personnel may be used to augment the staffing at operational civilian medical facilities.

- Preemptive PVNTMED actions can reduce the incidence of morbidity and mortality due to preventable causes of disease (control of disease vectors and rodents, disruption of sanitation facilities, waste disposal, and sewer systems). Additionally, PVNTMED resources are required to ensure the safety of the water supply in the AO.

- Veterinary resources are required to ensure the wholesomeness and safety of the food supply in the disaster area. This is of particular importance in an NBC contaminated environment.

b. As the immediate patient work load decreases, emphasis of support can shift from trauma management to other types of support. Mental health personnel can conduct surveys and provide intervention as required. Veterinary personnel can tend to injured livestock, pets, and wild animals. Depending upon regulations governing temporary housing or life support centers, veterinary help may be required with privately owned pets not allowed to stay with their owners in these facilities. Community health nurses, dietitians, and physical and occupational therapists can begin to work with disaster victims on activities of daily living and meeting their day-to-day health care needs.

c. A goal-oriented approach to disaster assistance must incorporate the reassumption of responsibility by the local community in the disaster area. Within the medical arena, this may require assistance in rebuilding the medical infrastructure, repairing and/or replacing facilities, and decreasing the dependence on military medical assistance. A desired end state should be determined and a time line established for the withdrawal of military medical assistance. This is, of course, established in conjunction with the other agencies conducting relief operations.

K-4. Disaster Relief Task List and Status Board

During disaster relief operations, it is essential that the CHS provided be goal-oriented and continually monitored. It is important, therefore, to establish a task list for the specific operation. Further, a status board should be maintained to track the progress made toward the resolution of the relief effort.

a. The disaster relief task list will be comprised of different elements for each operation. This list is developed by the JTF surgeon/staff in coordination with other participants. Factors such as the cause of the disaster, resources available, time available, and other factors will differ from situation to situation. A sample task list is provided for a natural disaster. This task list (Table K-1) should not be considered all-inclusive and should be tailored to the specific operation.

Table K-1. Sample disaster relief task list

• ESTABLISH COMMUNICATIONS WITH THE DOD CHS COORDINATOR WITHIN THE AOR.
• AUGMENT CIVILIAN HOSPITALS WITHIN THE RESOURCES OF THE DEPLOYED TF STRUCTURE.
• PROVIDE ROUTINE CHS TO US MILITARY FORCES DEPLOYED.
• ESTABLISH CIVILIAN MTFs CAPABLE OF RESUSCITATION AND STABILIZATION.
• PROVIDE MEDICAL SUPPORT TO TEMPORARY FACILITIES PROVIDING SUPPORT TO DISASTER VICTIMS.
• ASSIST AND ORIENT LOCAL, STATE, AND FEDERAL CHS ORGANIZATIONS CONDUCTING DISASTER RELIEF OPERATIONS.
• ESTABLISH PVNTMED PROGRAMS FOCUSED ON PEST MANAGEMENT, FIELD SANITATION, AND PMM FOR VICTIMS OF THE DISASTER AND THE TEMPORARY AREAS ESTABLISHED FOR HOUSING AND FIELD FEEDING.
• ESTABLISH A SINGLE POINT OF CONTACT FOR CHL.

b. To ensure that the status of each CHS functional component is monitored during the relief operation, a status board should be prepared. This status board (Figure K-1) should provide a visual update at a glance. The information can be displayed as a gum-ball chart depicting the civilian community's capability to provide its own support. The colors and their definition could be—

- Green for nearly full predisaster capability.
- Amber for some capability (50-75 percent).
- Red for little or no capability; requires significant DOD assistance.

PUBLIC HEALTH STATUS OF _____

FROM _____ **TO** _____

FUNCTIONAL AREA	GREEN	AMBER	RED
PATIENT EVACUATION AND MEDICAL REGULATING	O	O	O
AREA SUPPORT/EMERGENCY TREATMENT	O	O	O
HOSPITALIZATION/MEDICAL TREATMENT FACILITIES/MEDICAL LABORATORY SUPPORT	O	O	O
PREVENTIVE MEDICINE	O	O	O
VETERINARY SERVICES	O	O	O
COMBAT HEALTH LOGISTICS (INCLUDING BLOOD MANAGEMENT)	O	O	O
DENTAL SERVICES	O	O	O
MENTAL HEALTH SUPPORT	O	O	O
COMMAND AND CONTROL	O	O	O
COMMUNICATIONS	O	O	O

LEGEND:

GREEN—NEAR FULL PREDISASTER CAPABILITY.
AMBER—50–75 PERCENT OF CAPABILITY.
RED—LITTLE OR NO CAPABILITY.

Figure K-1. Sample status board.

APPENDIX L

SELECTED SECTIONS OF TITLE 10, UNITED STATES CODE, PERTAINING TO HUMANITARIAN ASSISTANCE

The information in this appendix is for informational purposes only. Combat health support commanders should ensure that a legal opinion from the Staff Judge Advocate has been obtained prior to the execution of any missions that are conducted which are governed by these sections of Title 10, US Code.

L-1. Humanitarian Assistance under Title 10, United States Code, Section 401

a. Humanitarian assistance is governed by Title 10, US Code, Section 401, which specifies: Humanitarian assistance—

- Must be carried out in conjunction with HN military or civilian personnel.
- Shall complement and may not duplicate any other form of social or economic assistance that may be provided to the HN by any other department or agency of the US Government.
- May not be provided directly or indirectly to any individual, group, or organization engaged in military or paramilitary activities.
- May not be provided unless the DOS specifically approves such assistance.

b. Medical humanitarian assistance includes assistance to a HN such as medical, dental, and veterinary care provided in rural areas of the country. (A medical mission reconnaissance checklist is provided in Appendix M.) This assistance complements, but does not duplicate, any other social or economic assistance that is being provided by other US departments or agencies. These activities serve the basic economic and social needs of the people of the country concerned; they—

- Support the civilian leadership.
- Benefit a wide spectrum of the community.
- Are self-sustaining (once completed) or supportable by the HN civilian or military agencies once US assistance is withdrawn.

c. Department of Defense humanitarian assistance programs promote the—

- Security interests of both the US and HN.
- Specific operational readiness skills of the Armed Forces who participate in the activities.

d. Humanitarian assistance projects or activities in any HN require specific prior approval of the Secretary of State for such assistance.

e. Expenses incurred as a direct result of providing humanitarian and civic assistance under this section to a foreign country shall be paid out of funds specifically appropriated for such purposes to include the following expenses:

(1) Travel, transportation, and subsistence expenses of DOD personnel providing such assistance.

(2) The cost of any equipment, services, or supplies acquired for the purpose of carrying out or supporting the activities, including any nonlethal, individual, or small team land mine clearing equipment or supplies that are to be transferred or otherwise furnished to a foreign country in furtherance of the provisions of assistance under this section.

f. The cost of equipment, services, and supplies provided in a fiscal year may not exceed $5,000,000.

g. Nothing in this section may be interpreted to preclude incurring of minimal expenditures by the DOD for purposes of humanitarian and civic assistance out of funds other than funds appropriated.

L-2. Transportation for Humanitarian Relief Supplies under Title 10, United States Code, Section 402

The transportation of humanitarian relief supplies to foreign countries is governed by Title 10, US Code, Section 402.

a. Notwithstanding any other provisions of law, and subject to subsection (b), The Secretary of Defense may transport to any country, without charge, supplies which have been furnished by a nongovernmental source and which are intended for humanitarian assistance. Such supplies may be transported only on a space available basis.

b. The Secretary may not transport supplies unless the Secretary determines that—

- Transportation of such supplies is consistent with the foreign policy of the US.
- Supplies to be transported are suitable for humanitarian purposes and are in usable condition.
- Legitimate humanitarian need exists for such supplies by the people for whom they are intended.
- Supplies will in fact be used for humanitarian purposes.
- Adequate arrangements have been made for the distribution of such supplies in the destination country.

c. The President shall establish procedures for making the determinations required under paragraph *b*. Such procedures shall include inspection of supplies before acceptance for transportation.

d. It shall be the responsibility of the donor to ensure that supplies to be transported under this section are suitable for transport.

(1) Supplies transported under this section may be distributed by an agency of the US government, a foreign government, an international organization, or a private nonprofit relief organization.

(2) Supplies transported under this section may not be distributed, directly or indirectly, to any group or organization engaged in a military or paramilitary activity.

L-3. Foreign Disaster Assistance under Title 10, United States Code, Section 404.

Foreign disaster assistance is governed by Title 10, US Code , Section 404.

a. *Presidential Direction.* The President may direct the Secretary of Defense to provide disaster assistance outside the US to respond to man-made and natural disasters when necessary to prevent loss of lives.

b. *Forms of Assistance.* Assistance under this section may include transportation, supplies, services, and equipment.

c. *Notification Required.* Not later than 48 hours after the commencement of disaster assistance activities to provide assistance under the section, the President shall transmit to Congress a report containing notification of the assistance provided, and proposed to be provided, under this section and a description of so much of the following as is then available:

(1) The man-made or natural disaster for which disaster assistance is necessary.

(2) The threat to human lives presented by the disaster.

(3) The US military personnel and material resources that are involved or expected to be involved.

(4) The disaster assistance that is being provided or is expected to be provided by other nations or public and private relief organizations.

(5) The anticipated duration of the disaster assistance activities.

L-4. Excess Nonlethal Supplies for Humanitarian Relief under Title 10, United States Code, Section 2547

The provision of excess nonlethal supplies for humanitarian relief is governed by Title 10, US Code, Section 2547.

a. The Secretary of Defense may make available for humanitarian relief purposes any nonlethal excess supplies of the DOD.

b. Excess supplies made available for humanitarian relief purposes under this section shall be transferred to the Secretary of State, who shall be responsible for the distribution of such supplies.

c. This section does not constitute authority to conduct any activity which, if carried out as an intelligence activity by the DOD, would require a notice to the intelligence committees under Title V of the National Security Act of 1947.

d. In this section, the term *nonlethal excess supplies* means property, other than real property, of the DOD, that—

(1) Is excess property, as defined in regulations of the DOD, and

(2) Is not a weapon, ammunition, or other equipment or material that is designed to inflict serious bodily injury or death.

L-5. Humanitarian Assistance under Title 10, United States Code, Section 2551

a. Authorized Assistance. To the extent provided in defense authorization acts, funds authorized to be appropriated to the DOD for a fiscal year for humanitarian assistance shall be used for the purpose of providing transportation of humanitarian relief and for other humanitarian purposes worldwide.

b. Availability of Funds. To the extent provided in appropriate acts, funds appropriated for humanitarian assistance for the purposes of this section shall remain available until expended.

c. Status Reports.

(1) The Secretary of Defense shall submit to the congressional committees an annual report on the provision of humanitarian assistance pursuant to this section for the prior fiscal year. The report shall be submitted each year at the time of the budget submission by the President for the next fiscal year.

(2) Each report shall cover all provisions of law that authorized appropriations for humanitarian assistance to be available to the DOD.

(3) Each report under this subsection shall set forth the following information regarding activities during the previous fiscal year.

(*a*) The total amount of funds obligated for humanitarian relief under this section.

(*b*) The number of scheduled and completed transportation missions for purposes of providing humanitarian assistance under this section.

(*c*) A description of any transfer of excess nonlethal supplies of the DOD made available for humanitarian relief. The description shall include the date of transfer, the entity to whom the transfer is made, and the quantity of items transferred.

APPENDIX M

MEDICAL MISSION RECONNAISSANCE CHECKLIST

M-1. General

a. The individual medical mission under a humanitarian assistance program requires comprehensive planning and prior coordination to ensure success. This appendix provides a sample checklist for completing a reconnaissance of the mission area prior to deployment of a medical team.

b. The terminology used to describe the different levels of the health care delivery system and its health care professionals in a particular country may vary from that provided in this checklist. This sample checklist, therefore, should be modified to conform to the health care delivery system in the AO.

M-2. Sample Medical Mission Reconnaissance Checklist

The sample medical mission reconnaissance checklist is provided in Figure M-1.

NAME OF VILLAGE _____
GRID _____
SHEET # _____

A. RESOURCES AVAILABLE IN VILLAGE AND SURROUNDING VICINITY.
- 1) COMMUNICATIONS MEANS, ACCESSIBILITY, AND EMERGENCY SERVICES.
  - A) COMMUNICATIONS MEANS: TELEPHONE _____ TELEGRAPH _____ OTHER _____
  - B) TYPE OF ROAD NETWORK: PAVED _____ DIRT _____ PATH _____
  - C) FIRE/SEARCH AND RESCUE SERVICES (LOCATION): _____
  - D) POLICE: _____ MILITIA: _____
- 2) HEALTH WORKERS.
  - A) *HEALTH GUARDIAN: _____
  - B) *MIDWIFE: _____
  - C) *HEALTH REPRESENTATIVE: _____
- 3) OTHER PERSONNEL AVAILABLE.
  - A) SCHOOL TEACHER: _____
  - B) VILLAGE LEADER: _____
  - C) OTHERS: _____
    _____
- 4) *NEAREST MEDICAL CLINIC.
  - A) DISTANCE: _____
  - B) TRANSPORTATION AVAILABLE: _____
  - C) NUMBER AND TYPE OF STAFF (TO INCLUDE SPECIALTIES): _____
    - (1) *NAME OF THE HEAD NURSE: _____
    - (2) *NAME OF THE HEALTH PROMOTER: _____
    - (3) OTHERS: _____
      _____

*TERMS FOR THESE INDIVIDUALS OR ORGANIZATIONS MAY VARY BETWEEN HEALTH CARE DELIVERY SYSTEMS.

Figure M-1. Sample medical mission reconnaissance checklist.

5) *NEAREST DISTRICT OR REGIONAL MEDICAL CLINIC.
   A) DISTANCE: _____
   B) TRANSPORTATION AVAILABLE: _____
   C) NUMBER AND TYPE OF STAFF: _____
      (1) *NAME OF THE PHYSICIAN (SOCIAL SERVICE): _____
      (2) OTHERS: _____
6) *NEAREST HOSPITAL (PUBLIC AND PRIVATE) AND TYPE OF HOSPITAL.
   A) *AREA HOSPITAL: _____ DISTANCE: _____
   B) *REGIONAL HOSPITAL: _____ DISTANCE: _____
   C) *NATIONAL HOSPITAL: _____ DISTANCE: _____
7) PRIVATE PHYSICIANS.
   A) NAME: _____
   B) ADDRESS: _____
   C) SPECIALTY: _____
8) ESSENTIAL DRUG LISTING (MEDICATIONS USED ON HUMANITARIAN ASSISTANCE MISSIONS SHOULD BE CONSISTENT WITH LOCAL PRODUCTS AND AVAILABILITY). _____
9) MEDICAL LOGISTICS AVAILABILITY (MATERIEL, SERVICES, AND REPAIR CAPABILITY). _____

B. HEALTH INFORMATION.
1) SIZE OF POPULATION.
   A) ADULTS: _____
   B) CHILDREN: _____
   C) INFANTS: _____
2) HOUSING AND ACCESSIBILITY OF HYGIENE AND SANITATION MEASURES.
   A) NUMBER OF HOUSES AND TYPICAL TYPE OF CONSTRUCTION TO INCLUDE HEATING: _____
   B) LATRINES: _____
   C) WATER PUMP: _____
   D) WATER SOURCE AND HOW USED (BATHING, LAUNDRY, AND COOKING): _____
3) ENDEMIC DISEASES.
   A) _____
   B) _____
   C) _____
   D) _____
   E) _____
   F) _____

Figure M-1. Sample medical mission reconnaissance checklist (continued).

4) FIVE LEADING CAUSES OF DEATH.
   A) ADULTS: _____
   B) CHILDREN: _____
   C) INFANTS: _____
5) VETERINARY INFORMATION.
   A) NUMBER OF:
      (1) CATTLE: _____
      (2) HORSES/MULES: _____
      (3) GOATS: _____
      (4) PIGS: _____
      (5) DOGS/CATS: _____
   B) NUMBER OF ANIMALS WHICH DIED IN THE LAST 3 MONTHS: _____
   C) CAUSES OR REASONS OF DEATHS: _____
6) DENTAL CARE INFORMATION.
   A) GENERAL LEVEL OF ORAL HEALTH: _____
   B) ENDEMIC ORAL DISEASES: _____
   C) AVAILABILITY OF DENTAL CARE: _____
   D) *NAMES OF DENTAL CARE PROVIDERS: _____
7) GENERAL LIVING CONDITIONS.
   A) CLOTHES: _____ SHOES: _____ BAREFOOT: _____
   B) HOUSING: _____
   C) ELECTRICITY: _____
   D) NUMBER OF FAMILY RADIOS/TELEVISIONS: _____
   E) STORES: _____
   F) CROPS: _____
   G) MAIN FOOD SOURCES: _____
   H) MAIN SOURCES OF INCOME: _____ AVERAGE FAMILY INCOME: _____
   I) AVAILABILITY OF REFRIGERATION: _____
8) TYPE OF HEALTH CARE TO BE GIVEN: _____
9) ESTIMATION ON RELIABILITY OF INFORMATION: _____

C. TRANSPORTATION INFORMATION.
1) AIR.
   A) PILOTS WHO FLEW ASSESSMENT TEAMS: _____
   B) ADEQUATE LANDING ZONE FOR:
      (1) UH-1: _____
      (2) UH-60: _____
      (3) CH-47: _____
      (4) OTHERS: _____
   C) TRAVEL TIME: _____
2) GROUND.
   A) TYPE OF VEHICLE: _____
   B) TRAVEL TIME: _____

Figure M-1. Sample medical mission reconnaissance checklist (continued).

C) SPECIAL REQUIREMENTS (SUCH AS SNOW CHAINS): _____

D) OTHERS: _____

D. SECURITY INFORMATION.

1) THREAT: _____

2) HOST NATION AND US SECURITY FORCES IN THE AREA: _____

3) AGENCY RESPONSIBLE FOR PROVIDING SECURITY AND CROWD CONTROL: _____

_____

E. DIAGRAM OF MISSION AREA.

1) DRAW DIAGRAM (PLACE ON BACK OF SHEET). INCLUDE INFORMATION ON VILLAGE OR TOWN, STREAM FLOW, CATTLE CHUTES, CORRALS, AND CEMETERIES.

2) EXPLAIN ON-SITE TRIAGE: _____

3) EXPLAIN PATIENT FLOW: _____

4) OTHERS/REMARKS: _____

_____

_____

F. ITEMS REQUIRED TO SUPPORT MISSION: _____

G. PHOTOGRAPHS OF SIGNIFICANT FEATURES AND PEOPLE: (*ATTACH TO REPORT)*

H. ASSESSMENT MADE BY:

1) OIC/NCOIC: _____

2) PHYSICIAN/NURSE: _____

3) OTHERS: _____

_____

I. EXPECTED DATE OF MISSION: _____

Figure M-1. Sample medical mission reconnaissance checklist (continued).

APPENDIX N

COMBAT HEALTH SUPPORT OF SPECIAL OPERATIONS FORCES

N-1. Special Operations

a. Special operations (SO) are operations conducted by specially trained, equipped, and organized DOD forces against strategic or tactical targets in pursuit of national military, political, economic, or psychological objectives. These operations may be conducted during periods of peace or hostilities. They may support conventional operations or they may be prosecuted independently when use of conventional forces is either inappropriate or not feasible.

b. Because one of the missions of SO involves training HN military to be self supportive, an exception to the normal funding source is provided under Section 2011 of Title 10, US Code, permitting the use of operation and maintenance funds when SO units are practicing their training skills in a HN. The benefit that the HN derives as a result of this instruction is considered by Congress as a consequential benefit.

c. The medical capabilities and requirements for support of each Service's SO component are discussed in Joint Pub 3-05.3.

N-2. Department of the Army Special Operations Forces

The five component elements of the Army special operations forces (ARSOF) are:

- Special Forces.
- Rangers.
- Psychological operations (PSYOP).
- Special operations aviation (SOA).
- Special operations support.

N-3. The Threat to Special Operations Forces

The threat to SOF varies with the environment, geographic area, mission, and level of hostilities. The specific threat to SOF encompasses the same threat facing conventional forces. Further, from the moment SOF are inserted in small groups into an area by land, sea, or air, they must be able to survive; operate deep in opposing force-held areas without being detected; and work closely with friendly, indigenous personnel.

N-4. Special Operations Forces Missions

a. Special operations forces missions are normally conducted as joint or combined operations across the full range of military operations.

(1) In accordance with Section 167, Title 10, US Code, the following are the principal SOF missions:

- Counterproliferation.
- Special reconnaissance (SR).
- Psychological operations.
- Direct action.
- Foreign internal defense.
- Civil affairs.
- Combatting terrorism.
- Information warfare.
- Unconventional warfare.

(2) Special operations forces collateral activities are—

- Coalition support.
- Counterdrug operations.
- Countermine operations.
- Humanitarian assistance.
- Security assistance.
- Special activities.

b. Special operations forces can provide an extra dimension to the battlefield through their unique and flexible capacity to affect operations in the deep, close, and rear battle areas.

N-5. Command and Control

a. Special operations forces are theater-level assets when deployed into an AO. Operational- and tactical-level commanders request SOF through the unified CINC. The SOF C2 element is established at any headquarters, combined or US, employing SOF. This ensures that unique mission requirements and employment procedures are met.

b. The CINC directs theater SO and the employment of SOF through his subordinate special operations command (SOC). The theater SOC is a joint command that controls ARSOF, USN, and USAF SOF. As strategic assets, SOF elements are deployed to the TO and placed under SOC operational control.

c. Special operations forces units do not have an organic combined arms capability and are not designed for sustained combat operations. Special operations forces require the support or attachment of other combat, CS, and CSS resources (units/elements/personnel). Special operations forces units are entirely dependent upon the resources of the theater to support and sustain their operations.

N-6. Army Special Operations

a. The SF group is a unique combat arms organization capable of planning, conducting, and supporting SO activities in all operational environments and in peace, conflict, and war. Special Forces units are characterized by the quality, motivation, training, and individual skill of their members. These characteristics produce units with superb collective skills, able to adapt well to dynamic, complex situations.

(1) The SF group consists of a group headquarters and headquarters company, a group support company, and three SF battalions. The group can operate as a single unit, but normally the battalions plan and conduct operations from widely separated locations.

(2) The SF company consists of a company headquarters ("B" detachment) and six operational detachments ("A" detachments or ODAs). The ODA (twelve-man team) is the basic SF unit and is specifically designed to conduct SO activities in remote areas. This unit can operate for extended periods with a minimum of external direction and support. The high-grade structure and experience level of the ODA is required to permit it to develop, organize, equip, train, and advise or direct indigenous military and paramilitary organizations of up to battalion size. For other SO activities that do not require its full capabilities, the ODA serves as a manpower pool from which SF commanders organize tailored SF teams to execute specific missions.

b. The Ranger regiment is a unique light infantry unit capable of planning, conducting, and supporting SO activities. The Ranger regiment provides the NCA with the capability to deploy a credible military force quickly to any region of the world. The primary Ranger mission in SO is to conduct direct action operations best accomplished by light infantry forces using special techniques. Ranger direct action operations may support or may be supported by other SO activities, or they may be conducted independently or in conjunction with conventional military operations.

c. The SOA regiment is a unique Army aviation unit that provides dedicated combat aviation support to Army and other SOF. This support is provided in all operational environments and in peace, conflict, and war. Because of current force structure and contingency requirements, the regiment does not operate as a single unit. Instead, it tailors the SOA battalion or company task forces to perform specific missions. The primary mission of SOA assets is to clandestinely penetrate hostile and sensitive airspace to conduct and support SO activities.

d. United States Army Reserve CA units have public welfare teams with various medical specialties. These teams can train, advise, and assist US and indigenous forces in the conduct of medical assistance to command operations and facilitate their integration due to their training.

e. Psychological operations are planned operations to convey selected information and indicators to foreign audiences to influence their emotions, motives, and objective reasoning. These operations ultimately influence the behavior of foreign governments, organizations, groups, and individuals. Army PSYOP units may be employed by the NCA in pursuit of national security objectives or by a theater-level commander in pursuit of operational objectives. These PSYOP may be designed to maintain the support of groups and nations friendly to the US; gain support and cooperation of neutral countries; strengthen or alter alliances; deter a nation from aggression; and induce the surrender of hostile forces.

N-7. Organic Combat Health Support Capability

The organic CHS capability of SOF units is limited. Consequently, SOF are dependent upon the conventional CHS structure for medical support in theater. Special operations forces missions rely on organic assets to perform Echelon I medical care. Echelon II, (division level), Echelon III (corps level), and Echelon IV (echelons above corps [EAC] level) medical care must be provided to the force.

a. Special Forces.

(1) The SF group has the capability to perform enhanced Echelon I medical care. Individual care consists of self-aid and buddy aid, combat lifesaver, and aidman (SF medic [MOS 18D]) care. There are two SF medics assigned to each ODA. The SF medic is extensively trained to act independently, often as the sole source for medical, veterinary, dental, and PVNTMED care for his ODA and the indigenous personnel (and their families) with whom his ODA interfaces. The SF medic is also uniquely qualified to act as a trainer for indigenous and civilian medical personnel. The SF medic and other more specialized medical assets within the SF group can provide limited support in the following areas:

- Preventive medicine.
- Medical intelligence.
- Veterinary and dental medicine.
- Laboratory support for clinical diagnosis.

- Minor surgery.
- Short-term trauma management.
- Training for HN health care workers in medical, veterinary, dental, and PVNTMED skills.

(2) A flight surgeon and physician assistant (PA) are assigned to each SF battalion. At the forward operating base (FOB), the flight surgeon and PA can perform ATM procedures and provide limited resuscitative care. Further, the FOB has a PVNTMED noncommissioned officer (NCO) capable of providing medical threat evaluation and limited direct PVNTMED support.

(3) The Special Forces operating base (SFOB) has a flight surgeon, dental officer, veterinary officer, medical operations officer, CHL officer, and an environmental science officer assigned. At this level, the medical officers perform primarily as staff advisors to the group commander and provide medical staff assistance to the deployed SF battalions. They can also assist in the training of HN medical assets.

(4) The medical platoon of the ARSOF special operations support battalion (SOSB) provides Echelon I medical care to its supported ARSOF units. (The full range of Echelon II through Echelon IV support must be provided to the force.)

- It also provides—
  - Limited ground evacuation of the sick, injured, and wounded.
  - Limited medical intelligence capability.
  - Communications capability.
- The platoon is organized into a headquarters and treatment section, an ambulance section, and a medical logistics section.
- For additional information, refer to FM 8-10-1.

b. Rangers.

- The Ranger regiment has the capability to perform Echelon I and limited Echelon II care. Echelon III care must be provided to the force by conventional CHS resources.
- Rangers have organic CHS assets, but they do not have an aid station (treatment squad) capability.
- A general medical officer and a PA are assigned to each Ranger battalion. The Ranger regiment, battalion, and company headquarters are each assigned one MOS 18D, SF medical sergeant. Platoons are each assigned MOS 91B, medical specialists.

c. Special Operations Aviation.

- Special operations aviation has a flight surgeon and a psychiatrist assigned at group level.

- Special operations aviation is dependent on area CHS from units it is supporting (typically the SFOB).

- Special operations aviation units do not have specifically designated medical aircraft with a primary mission of medical evacuation. Evacuation by nonstandard aircraft is emphasized and augmentation from supporting Echelon II assets is encouraged.

- Like other SO medical assets, SOA medical personnel can provide limited flight medical training for HN aviation personnel.

d. Psychological Operations.

- Psychological operations units have no organic CHS. They are dependent on area CHS from the theater medical command (MEDCOM).

- Psychological operations units also require timely and accurate information on all public health and HN support initiatives to accomplish their mission.

e. Civil Affairs. United States Army Reserve CA battalions have public welfare teams with various skills. Their expertise gives them unique qualifications to provide guidance on the HN health care infrastructure, as well as PVNTMED issues.

N-8. Planning for Combat Health Support of Special Operations Forces

Special operations forces units require CHS similar to other combat, CS, and CSS units. They also need medical intelligence to counter the medical threat. The support should include all of the medical functional areas.

N-9. Patient Evacuation and Medical Regulating

Aeromedical evacuation of SOF is indicated only when it will not compromise the mission. Combat health support planners must ensure there is adequate medical evacuation capability, both intertheater and intratheater. If SOF assets are used, as will probably be the case in intratheater evacuation, medical assets must be on board to provide medical care en route. Combat health support planners must ensure that SOF have their own evacuation policy to allow return of critical SOF MOSs to their units instead of being evacuated out of theater. Early coordination must be made with in-theater USAF assets or supporting SOA assets to ensure timely intertheater evacuation capability. The SOSB has a limited ground evacuation capability within the staging base. Echelons I through III medical care is a service responsibility. Intratheater medical regulating of ARSOF is normally an Army function. The transfer of patients from an Echelon III

Army MTF to an Echelon IV facility is a theater (or joint) function; therefore, intratheater and intertheater medical regulating is usually a function of the TPMRC and GPMRC. Medical regulating is not an ARSOF function since units are neither staffed nor equipped to accomplish this mission. It is essential that surgeons at all levels understand how patients are regulated within and between theaters, and how they can track them through the system.

N-10. Hospitalization

Special operations forces do not have an organic Echelon III capability. They rely on the theater MEDCOM hospitalization system for their patients in the combat zone and EAC; in an underdeveloped theater or AO, SOF may rely on the HN to provide hospitalization. When the sensitivity of a particular mission dictates strict OPSEC, the SOC must coordinate with the MEDCOM to establish facilities capable of handling patients on a classified basis.

N-11. Combat Stress Control

a. Combat fatigue cases should be managed as far forward as possible to preclude unnecessary loss of personnel, hasten RTD, and prevent overburdening the medical evacuation system.

b. Army SOF do not have organic CSC teams; support is required from the theater MEDCOM.

N-12. Preventive Medicine

A major shortfall of SOF CHS is the lack of PVNTMED assets for extensive PVNTMED area support (such as aerial spraying and larviciding). Although SF medics are trained in the basics of PVNTMED, the SF group has limited assets and capabilities to plan, coordinate, and supervise PVNTMED programs to the extent that is required. Other SOF units have even less PVNTMED capabilities. Given the nature of SOF operations which places personnel at serious risk for disease and environmental injury, a full-time PVNTMED commitment may be required, necessitating the use of theater PVNTMED support. Education and thorough indoctrination to the risks, surveillance procedures, and PMM are continually required to safeguard the health and readiness status of the operational force. The PVNTMED NCOs in the SF battalions and the SOSB provide technical assistance to the unit field sanitation teams and advise the commander on the control measures required to protect the force.

N-13. Medical Intelligence

Research specialists are dedicated to researching and compiling medical threat information in all foreign countries and disseminating this information to all deploying SOF elements. The United States Special Operations Command (USSOCOM) medical intelligence section is the interface between SOF and AFMIC. Medical intelligence maintains comprehensive classified and unclassified hard copy and electronic data bases in support of SOF deployments for training and security assistance commitments. It also maintains

extensive liaison with intelligence and medical networks within USSOCOM, AFMIC, Defense Intelligence Agency (DIA), and other agencies. This section compiles new critical elements of information received from teams operating in the field for dissemination in future deployments. After-action reports (AARs) containing medical information have proven to be critical in planning operations. The PVNTMED branch and medical intelligence section work together in recognizing the threat and recommending countermeasures to this threat.

N-14. Veterinary Services

Special Forces groups have limited veterinary services. When veterinary services are required in more than one location or when the SOF are larger than two deployed FOBs, veterinary support must be augmented. Veterinary personnel must perform the majority of the food source inspection mission.

N-15. Medical Laboratory Services

The SF group ODA is the only SOF unit with a limited laboratory capability. The SO medical sergeant (MOS 18D) is trained to provide basic clinical laboratory tests and procedures in support of UW or FID missions. Echelon III laboratory support is required from the theater.

N-16. Combat Health Logistics and Blood Management

The medical sections of all SOF units maintain a Class VIII (medical supply) basic load to support initial operations. The SF group, SOSB, special operations support command (SOSCOM), and battalion medical sections are the only SOF elements with organic medical supply personnel. The SOSCOM provides the medical equipment support in SOF. No SOF unit has an organic medical equipment maintenance capability. These units receive routine CHL through their supporting medical logistics battalion. This support includes Class VIII supplies, oxygen, resuscitative fluids production, optical fabrication, medical equipment maintenance support, and blood management. To fill operational requirements in support of UW or FID, SF medical supply personnel at the SFOB and FOB requisition bulk Class VIII supplies directly from the supporting MEDCOM medical logistics battalion or installation CHL activity. Army SOF may also supplement their CHL effort with foreign national medical supplies, particularly during UW operations, if approved by the Food and Drug Administration (FDA) and theater surgeon.

N-17. Dental Services

The group's medical section includes a dental team (dental officer and dental assistant) who can provide emergency or sustaining dental care. The SF medics have limited dental training and equipment and can provide only emergency dental care.

N-18. Interrelated Missions

As previously stated, SOF units conduct nine basic missions and have a number of collateral capabilities (paragraph N-2 above.). Special operations forces elements conduct UW, FID, counterterrorism, direct action, and SR operations in peace, conflict, and war. Mission priorities vary from theater to theater. These elements are specifically tailored to organize, equip, train, direct, control, and support indigenous forces in FID and UW operations. They also perform SR, direct action, and counterterrorism operations and other missions requiring their collateral capabilities. Although each mission is treated separately, they are all interrelated. Some situations will dictate that a committed SOF element conduct more than one mission at the same time.

N-19. Unconventional Warfare

a. Unconventional warfare is a broad spectrum of military and paramilitary operations, normally of long duration, predominantly conducted by indigenous or surrogate forces who are organized, trained, equipped, supported, and directed in varying degrees by an external source. Unconventional warfare includes guerrilla warfare and other direct offensive, low-visibility, covert, or clandestine operations. Unconventional warfare also includes the indirect activities of subversion, sabotage, intelligence collection, and evasion and escape.

b. The goals of CHS in support of UW are to conserve the guerrilla force's fighting strength and to assist in securing local population support for US and insurgent forces operating within unconventional warfare operations area (UWOA).

c. Medical elements supporting the insurgent forces must be mobile, responsive, and effective in preventing disease and restoring the sick and wounded to duty. There is no safe rear area where the guerrilla takes his casualties for treatment. Wounded and ill personnel become a tactical rather than a logistical problem.

d. In a UW situation, indigenous medical personnel may provide assistance during combat operations by establishing casualty collecting points, thus permitting the remaining members of the insurgent force to continue to fight. Casualties at these collecting points are later evacuated to the guerrilla base or guerrilla medical facility. As the operational area develops, more seriously injured or diseased personnel are evacuated to friendly areas. Clandestine evacuation nets are established if security does not permit using aeromedical evacuation.

e. Medical requirements within the UWOA differ from those posed by conventional forces. Battle casualties are normally fewer and the incidence of disease and malnutrition is often higher.

N-20. Foreign Internal Defense

a. Foreign internal defense is the invited participation by civilian and military agencies of a government in any of the action programs taken by another government to free and protect its society from

subversion, lawlessness, and insurgency. These operations which may be international in makeup and involve more nations than the US are aimed at supporting a friendly government. The purpose of these operations is to protect internal development efforts that focus on the economic and social aspects of the nation's structure. Special operations forces are frequently deployed in regions where FID is a major DOD mission and, by virtue of their unique skills, language capability, and cultural knowledge, SOF medical assets are easily integrated into a HN support role. However, FID is not exclusively a SOF mission. It is a joint and interagency activity in which SOF participate. The primary SOF mission in this interagency activity is to organize, train, advise, and assist HN military and paramilitary forces.

b. Civil-military operations that focus on the relationship between US military forces and the indigenous population are critical for FID operations. Combat health support has proven to be one of the most effective ways to gain support for the HN government. Medical assistance is constructive in nature and is generally welcomed, rather than feared. Medical assistance programs are requested by the HN government. They are aimed at—

- Improving basic standards of living and health.
- Involving the local population.
- Enhancing the prestige of local authorities.

c. Combat health support may include, but is not limited to—

- Providing medical treatment.
- Providing education in basic sanitary procedures, hygiene, and PVNTMED.
- Providing sanitary facilities and waste disposal and controls.
- Improving the quality of drinking water.
- Conducting immunization programs.

N-21. Counterterrorism

a. Counterterrorism operations are offensive measures taken by civilian and military agencies of a government to prevent, deter, and respond to terrorism. The primary mission of SOF in this interagency activity is to apply specialized capabilities to preclude, preempt, and resolve terrorist incidents abroad.

b. Counterterrorism operations are either overt or covert in nature. They are characterized, in contrast to UW, as being of short duration and specifically targeted. During counterterrorism operations, tailoring of units and equipment is required. Medical personnel are needed at all levels of the operation, and medical equipment is selectively chosen for the operation.

c. Combat health support planning involves studying the mission and the AO to determine CHS requirements. Equipment is kept to a minimum to support emergencies and routine illnesses. Special packing of the equipment is considered, especially for raid-type missions, to make essential items immediately accessible. Pre-mission medical training concentrates on EMT, ATM, and treatment of mass casualties.

N-22. Direct Action

a. Special operations forces direct action missions are combat operations conducted or directed primarily by SOF in hostile or denied areas beyond the operational capability of tactical weapon systems and conventional maneuver forces. Direct action operations are normally limited in scope and duration, but they may include long-term stay-behind operations. These operations typically involve the interdiction of critical LOC or other target systems and the abduction, rescue, or recovery of selected personnel or sensitive items of material.

b. Combat health support of SOF direct action operations is generally directed toward providing evacuation and hospitalization. Since the majority of SOF direct action missions are conducted beyond the forward line of own troops (FLOT), aerial medical evacuation is required to remove casualties from the field when OPSEC is not endangered. Echelons II and III CHS are required on an area support basis from the theater MEDCOM.

N-23. Special Reconnaissance

a. Special reconnaissance is an intelligence collection activity conducted beyond the operational capabilities of tactical collection systems to obtain or verify information about the activities and resources of a target, organization, or group. Special operations forces SR missions are generally of short duration and involve small elements (squads, teams, split-teams). Special reconnaissance missions are "deep" operations conducted beyond the FLOT primarily in support of intelligence requirements of strategic importance.

b. Since SR missions are conducted deep in hostile or denied territory, CHS is limited. As aerial medical evacuation of SOF casualties would compromise the mission, the units rely on Echelon I (self-aid and buddy aid, combat lifesaver, and SF medic) until the mission is accomplished and the team is extracted.

c. Comprehensive medical intelligence is critical for SOF SR missions. The medical threat requires evaluation of PMM to counter the threat and to protect SR elements from exposure to disease and injury.

APPENDIX O

COMBAT STRESS CONTROL ACTIVITIES BY PHASE OF THE OPERATION

As in war, the primary mission of the AMEDD CSC assets is to assist leaders with sustaining mission focus and promoting positive combat behaviors; these behaviors include unit cohesion, vigilance, perseverance, and good discipline. Leaders must prevent misconduct stress behaviors, since serious misconduct, once committed, demands firm punitive action. Suicide prevention programs must be continued in stability and support operations. Sound leadership can prevent BF (or conflict fatigue). Further, should BF occur, strong leadership assures the soldiers rapid recovery in the unit. However, even soldiers who perform heroically throughout critical events can develop post-traumatic stress problems months to years later. The stresses of long deployments disrupt normal habits and family relationships. The CSC mission assists units with debriefings and management of critical events and with homecoming and reintegration. The DOD (Health Affairs) may continue to require MH screening of all personnel prior to redeployment from the theater (as in Operation Joint Endeavor), as part of the PVNTMED surveillance program. Table O-1 provides information on CSC activities by phase of the operation.

Table O-1. Combat Stress Control Activities

PREDEPLOYMENT	• BRIEF CSC MISSION AND ASSETS TO ALL UNITS. • GIVE SELECTIVE STRESS MANAGEMENT TRAINING. • ASSIST AO CULTURAL AND HISTORICAL TRAINING. • HELP PREPARE FAMILY SUPPORT GROUPS.
IN-COUNTRY ACTIVITIES	• ATTEND COMMAND AND STAFF BRIEFINGS, AS APPROPRIATE. • VISIT EVERY COMPANY-SIZED UNIT BIMONTHLY. • CONDUCT ROUTINE UNIT SURVEY INTERVIEWS. • ASSIST HUMAN DIMENSION TEAMS RESEARCH, WHEN APPLICABLE. • CONTINUE EDUCATION PROGRAMS. • EVALUATE AND ASSIST DISTRESSED SOLDIERS. • PROVIDE RESTORATION TREATMENT, WHEN NEEDED.
CRITICAL EVENT RESPONSE	• ASSIST OR LEAD CRITICAL EVENT DEBRIEFING. • ADVISE COMMAND, CHAPLAINS, AND MEDICAL PERSONNEL ON POLICIES AND MEMORIAL SERVICES.
REDEPLOYMENT ACTIVITIES/ RETURN TO HOME STATION	• ENCOURAGE END OF TOUR DEBRIEFINGS AND CLOSURE BY ALL UNITS. • ASSIST WITH REUNION ACTIVITIES. • CONDUCT DOD MH SCREENINGS, AS REQUIRED.

APPENDIX P

DEVELOPMENT OF MEDICAL ELEMENT TACTICAL STANDING OPERATING PROCEDURES

P-1. General

a. Combat health support elements employed in stability and support operations often have a high turnover rate of personnel due to short rotational assignments. To ensure continuity of programs and to facilitate the orientation of newly assigned personnel, it is important that a TSOP be developed. This TSOP should be quite detailed and cover all aspects of the CHS element operations, such as—

- Medical procedures and services (can be part of the TSOP or developed as a separate clinical standing operating procedure [CSOP]).
- Supply and resupply procedures (both medical and nonmedical materiel).
- Unit administration.
- Medical records and administration.
- Mass casualty plans.
- Joint and multinational force and HN coordination requirements.

b. This appendix provides a skeletal outline of topics that should be included in the element's TSOP. The CHS element defined in this appendix is task-organized and has a surgical element; not all units employed in stability and support operations will have this capability or the other full range of functions defined (such as veterinary services). It may be modified to meet the needs of the unit. The TSOP should be updated on a regular basis.

c. Procedures should be formally established within the element (to include an out-briefing by the departing commander on the adequacy and scope of the TSOP).

P-2. Purpose of the Tactical Standing Operating Procedure

The TSOP prescribes policy, guidance, and procedures for the routine field operations of a specific unit. It should cover broad areas of unit operations but be sufficiently detailed to provide newly assigned personnel the guidance required for them to assume their new positions. A TSOP may be modified by TSOPs and OPLANs/OPORDs of higher headquarters. It applies to the parent unit and all subordinate units assigned and attached. Should the TSOP not conform to the TSOP of the higher headquarters, the higher headquarters' TSOP governs. The TSOP should be periodically reviewed and updated as required.

P-3. Format for the Tactical Standing Operating Procedure

a. There is not a standard format for all TSOPs; however, it is recommended that a particular unit's TSOP follow the format used by its higher headquarters. The TSOP can be divided into sections (functional areas or major operational areas). The TSOP can contain one or more annexes, each of which may have one or more appendixes. The appendixes may have one or more tabs. Appendixes can be used to provide detailed information on major subdivisions of the annex; tabs can be used to provide additional information (such as report formats or area layouts) addressed in the appendix.

b. Regardless of the format used, the TSOP should follow a logical sequence in the presentation of material. As a minimum, it should discuss the—

- Chain of command and/or coordination/cooperation arrangements .
- Major functions and staff sections of the unit.
- Operational requirements, to include ROE.
- Required reports.
- Necessary coordination with higher and subordinate elements, joint or multinational forces, HN forces and agencies, other US agencies, NGOs, and PVOs for mission accomplishment, as appropriate.
- Programs (such as command information or PMM).
- Other relevant topics (such as instruction of the culture, customs, and beliefs of the HN or other countries involved in the mission).

c. Pagination of the TSOP can be accomplished starting with page 1 and numbering the remaining pages sequentially. If the TSOP is subdivided into sections, annexes, appendixes, and tabs, a numbering system that clearly identifies the location of the page within the document can be used. Annexes are identified by letters and arranged alphabetically. Appendixes are identified by numbers and arranged sequentially within the specific annex. Tabs are identified by a letter and are listed alphabetically within the particular appendix. After numbering the initial sections using the standard numbering system (sequentially starting with page 1 through to the end of the sections); number the annexes and their subdivisions. They are numbered as the letter of the annex, the number of the appendix, the letter of the tab, and the page number. For example, page 4 of Annex D is written as "D-4"; page 2 of Appendix 3 to Annex D is written as "D-3-2"; page 5 of Tab A to Appendix 3 of Annex D is written as "D-3-A-5." This system of numbering makes the pages readily identifiable as to their place within the document.

d. In addition to using a numbering system to identify specific pages within the TSOP, descriptive headings should also be used on all pages to identify subordinate elements of the TSOP.

(1) The first page of the TSOP should be prepared on the unit's letterhead. The remaining pages of the major sections should include the unit identification in the upper right hand corner of the page; for example, "_____Medical Company."

(2) A sample heading for an annex is "ANNEX C (Administration and Personnel) to _____Medical Company."

(3) A sample heading for an appendix is "APPENDIX 2 (Personnel Management) to ANNEX C (Administration and Personnel) to _____Medical Company."

(4) A sample heading for a tab is "TAB A (Award Recommendations) to APPENDIX 2 (Personnel Management) to ANNEX C (Administration and Personnel) to _____Medical Company."

e. As the TSOP is developed, there may be an overlap of material from one annex to another. This is due in part to similar functions that are common to two or more unit elements. Where overlaps occur, the material presented should not be contradictory. All discrepancies will be resolved prior to the authentication and publication of the TSOP.

P-4. Orientation of Newly Assigned Personnel

a. Newly assigned personnel must be adequately oriented to their new positions. On tours of duty with a duration of 6 months to 1 year, it is important that personnel have ready access to procedures and guidelines to rapidly assimilate them into the operation. This enhances their effectiveness and maximizes their contribution to the unit mission. In many stability and support operational missions, US Army Reserve units may perform their 2 weeks of active duty for training in OCONUS CHS elements. A thorough orientation on their role and the procedures to be followed enhances the training they receive.

b. Orientation should include—

- Units goals, objectives, and mission.
- Unit history.
- Rules of engagement.
- Existing Status of Forces agreements.
- Cultural, political, and economical considerations of the HN.
- Language requirements and, if personnel are not fluent in the HN's language, availability of interpreters and cross-referenced language dictionaries (such as a Spanish-English dictionary). The element should develop its own cross-referenced training aid with common medical questions and phrases for use by nonfluent personnel. (Department of the Army Pamphlet 40-3 provides medical phrases in the following languages: English, French, Danish, German, Greek, Italian, Dutch, Norwegian, Turkish, and Portuguese.)

- Medical threat in the region.
- General threat and individual and force protection measures needed to ensure individual and unit survivability (including terrorism awareness).
- Standards of conduct (both in the military setting and in the civilian community).
- Administrative, personnel, and finance support.
- Specific job-related information and procedures.
- Population served and eligibility for care.

c. If facilities are available to make training aids, such as film strips, the portions of the orientation dealing with topics that remain fairly constant can be standardized. These topics can include the cultural, economical, and political considerations of the HN and the unit history. If this is not possible, a prepared briefing and handouts can be used.

P-5. Tactical Standing Operating Procedure (Sections)

The information contained in this paragraph is an outline of the information which may be included in a TSOP. It is not to be considered an all-inclusive listing. Without supplementation as to specific guidance and policies, this TSOP cannot be executed as written.

- First section. (*Identifies unit/element it pertains to*.)
  - Scope.
  - Purpose.
  - Applicability.
  - References.
  - General information.
- Second section. (*Identifies organizational design*.)
  - Organization.
  - Task organization.
  - Organizational charts.

- Third section. (*Discusses unit functions.*)
    - Unit headquarters.
    - Staff responsibilities.
- Fourth section. (*Contains the annexes and provides required procedures/guidance.*)

P-6. Tactical Standing Operating Procedure (Annexes)

Annexes are used to provide detailed information on a particular function or AOR. The commander determines the level of specificity required for the TSOP. Depending upon the complexity of the material to be presented, the annex may be further subdivided into appendixes and tabs. If the annex contains broad guidance or does not provide formats for reports, paragraphs may be used and the annex need not be further subdivided. However, as the material presented becomes more complex, prescribes formats, or contains graphic material, the annex will require additional subdivision. This paragraph discusses the subdivision of annexes by appendixes. It does not contain examples of subdividing the information presented in the appendixes into tabs. Applicable references, such as ARs, FMs, and TMs, should be provided in each annex. The number of annexes and their subdivisions presented below are not to be considered an all-inclusive listing. Different commands have unique requirements; therefore, supplementation of the information presented is permitted.

a. Annex A. (Organizational Charts).

b. Annex B. (Command Post). (*This annex discusses the operation of the command post, its staffing, and its functions.*)

- General.
- Force protection.
- Security.
- Camouflage (*when directed*).
- Message distribution.
- Joint/combined liaison. (*This can be a discussion of interpreters, liaison officers/teams, or other coordination requirements in joint and multinational operations.*)
- Journal (duty log), situation map, and information display.
- Combat health support overlays.

- Nonmedical overlays.
- Communications procedures and security.

c. Annex C. (Administration and Personnel). (*This annex outlines procedures relating to administrative and personnel matters and associated activities.*)

- Personnel accountability.
- Personnel management.
- Personnel services.
- Mortuary affairs.
- Public information.
- Maintenance of law and order.
- Enemy prisoners of war/detainees.

d. Annex D. (Intelligence and Security). (*This annex pertains to intelligence requirements and procedures and OPSEC considerations.*)

- Intelligence.
- General threat.
- Medical threat.
- Weather.
- Captured/detained personnel and captured or abandoned equipment, supplies, and documents.
- Security.

e. Annex E. (Operations). (*This annex establishes policy and procedures for unit operations.*)

- Operational situation report.
- Operations security countermeasures.
- Development of estimates, OPLANs, and OPORDs.

- Risk assessment and safety guidance.
- Communications-electronics (*to include procedures and security*).
- Reporting requirements and formats.
- Briefing requirements, recurring meetings, and readiness reporting.
- Predeployment/deployment operations.

f. Annex F. (Unit Layout). (*This annex discusses the establishment and breakdown of the unit area. The patient treatment areas must be arranged so that patient flow and ambulance turnaround are unimpeded.*)

- Advance party/quartering party.
- Site selection.
- Force protection considerations (*to include patient bunkers, listening posts, observation posts, and individual fighting positions*).
- Establishment of treatment areas (*which facilitate patient flow*).
- Establishment of and safety considerations for x-ray machines.
- Establishment of ambulance turnaround and helicoptering landing areas.
- Establishment of patient decontamination station.
- Establishment of administrative areas, sleeping areas, and motor pool.
- Plan for reconfiguration of triage/treatment areas for mass casualty situations.
- Establishment of field sanitation facilities (*latrines, handwashing facilities, soakage pits, and waste disposal sites/measures*).

g. Annex G. (Nuclear, Biological, and Chemical Defense). (*This annex prescribes policies, guidance, and procedures for NBC defensive measures. Exposure may result from such activities as an explosion at a nuclear power plant or as a result of a terrorist attack.*)

- Responsibilities.
- Protection measures for unit members and patients under their care.
- Reporting requirements and procedures.

- Unit decontamination procedures.

- Patient decontamination operations (*to include coordination for nonmedical personnel to perform patient decontamination procedures*).

h. Annex H. (Logistics). (*This annex establishes logistics procedures for the unit. It concerns both general supply and CHL. Combat health logistics should also be addressed under the MTF operations.*)

- General supply and services.

- Property book management.

- Combat health logistics support (*to include emergency resupply measures, blood management, controlled substance control, and inventory control*).

- Power generation equipment/operations.

- Food service.

- Bath and laundry service.

- Transportation and movement requirements.

- Fire prevention and protection.

- Field hygiene and sanitation.

- Motor pool operations.

- Conventional ammunition down- and upload procedures, storage, safety, and issuance.

- Petroleum, oils, and lubricants accounting.

- Maintenance (nonmedical).

- Medical equipment maintenance.

i. Annex I. (Safety). (*This annex establishes minimum essential safety guidance for the unit and provides guidance on the unit's risk assessment program.*)

j. Annex J. (Civil-Military Operations). (*This annex discusses participation in CMO activities. In stability and support operations, this annex takes on an added importance. It should be reviewed often and revised as necessary.*)

- Liaison/interpreters.

- Status of Forces agreements.
- Customs, beliefs, religious affiliations, and economical, political, and social considerations.
- Type of operation. (*The type of operation will normally dictate the extent of involvement with the civilian community in the AO.*)
- Availability/capability to contract for goods and services.
- Coordination/cooperation requirements with NGOs and PVOs.
- Coordination with the civilian medical infrastructure.

k. Annex K. (Medical Treatment Facility Operations). (*This annex provides the guidance for the actual medical treatment, evacuation support, and other CHS activities conducted by the unit. It can also be prepared as a separate CSOP.*)

(1) Medical evacuation and medical regulating.

- Request formats.
- Evacuation overlays.
- En route care protocols.
- Ground ambulances.
  - Medical equipment sets.
  - Loading plan.
  - Medical equipment maintenance/calibration.
  - On-board oxygen.
  - Radio procedures.
  - Routes (*to include reconnaissance of, obstacles, or other pertinent information*).
  - Strip maps.
  - Dispatch of ambulances.
  - Drivers licenses.

- Driver briefings.
- Ambulance shuttle operations.
- Ambulance exchange point operations.

- Air ambulances.
  - Army airspace command and control.
  - Weather.
  - Launch authority.
  - Stationing plan.
  - Fuel.
  - Maintenance support.
  - Flying hours program.
  - Crew rest.
  - Flight surgeon support.
  - Billeting and feeding.
  - Landing zone (*to include security*).
  - Community assistance programs.
  - Medical equipment sets.

- Responsibilities of each person (*requester, medical personnel, or evacuation element*).

- Documentation requirements (*to include USAF required forms when the unit is the OMF for USAF evacuation*).

- Coordination with other Services when providing area support.

(2) Medical and dental services and clinics.

(*a*) A number of standard elements should be covered for all medical and dental services and clinics. These are—

- Organization and functions.
- Administration (*to include policies, goals, objectives, reporting requirements, duties and responsibilities, location, and hours of operation*).
- Examination procedures.
- Treatment protocols.
- Credentialing.
- Combat health logistics supply and resupply procedures, equipment availability, and maintenance/repair capability.
- Infection control.
- Equipment and supplies listing or locally determined MESs for operations away from the permanent clinic site.
- Eligibility for care.
- Safety.
- Fire evacuation plan.
- Host-nation coordination requirements.
- In-service education requirements and continuing education programs.
- Standing committees (*such as quality assurance, credentialing, or other medical-specific committees*).
- Accident reporting.
- Personal appearance and behavior standards.
- Electrical power requirements and means to support requirements.

(*b*) Considerations for specific services and clinics are—

- Dental services.
    - Radiographic procedures, and availability of services.

- Medical equipment maintenance and repair (*to include calibration of x-ray equipment and safety measures*).
- Personal (universal) protection (*such as gloves, eye protectors, and mask*).
- Requirements for refrigeration.
- Recovery of precious metals.
- Sterilization of instruments (*cold sterilization procedures if sterilizer is not available*).
- Alternate wartime role of dental officers.

- Pharmacy service.
  - Formulary that covers the prescribing procedures, alphabetical listing of drugs, and a therapeutic category listing.
  - Signature cards.
  - Controlled substance inventory, dispensing requirements, register, destruction procedures, discrepancy report, and requisitions.
  - Access letters.
  - Key control.
  - Intravenous admixture program, if applicable.
  - Pharmacy waste disposal.
  - Humanitarian assistance involvement, requirements, and mission.
  - Work report including inpatient and outpatient bulk order and sterile products, if applicable.
  - Requirements for refrigeration.
  - In-service training requirements.
- Laboratory service.
  - Procedures for preservation and transport of clinical specimens to supporting laboratories within the theater or to CONUS.

- Quality assurance program.
- Procedures for the preservation and transport of biological specimens for detection of NBC agents to supporting laboratories.
- Infection and chemical hazard control.
- Requirements for refrigeration.
- Procedures and logistics of blood banking.
- Blood reports and requisitioning.
- Currency of reagents.
- Procedures for hematology laboratory.
- Procedures for biochemistry and clinical chemistry laboratory.
- Procedures for bacteriology and parasitology.
- Medical equipment maintenance and repair.

- Anesthesia services.
  - Standards.
  - Duty roster and on-call requirements.
  - Master list of clinical procedures.
  - Equipment checklists.
  - Classification of patients.
  - Narcotics control.
  - Infection control in work area.
  - Anesthesia carts.
  - Disposition of syringes and needles.
  - Storage of combustibles and cleaning schedule.
  - Quality control procedures for equipment.

- Surgical service.
    - Scheduling procedures (*to include after-hours and emergency cases*).
    - Aseptic (sterile) technique.
    - Maintenance of registry.
    - Scrub attire and surgical hand scrub procedures.
    - Environmental safety.
    - Electrosurgical unit safety.
    - Operating room environmental sanitation.
    - Counts of sponges and sharps.
    - Bullet removal—evidence and property custody document.
    - Death procedures (*notifications; autopsy* [*to include coordination with HN health officials or compliance with valid agreements*]*; and disposition*).
    - Cardiac arrest procedures.
    - Traffic patterns (*transportation of patients to and from the operating room; transportation of sterile, clean, and dirty equipment; evacuation of personnel and patients during contingencies*.)
    - Handling of contaminated needles and syringes.
- Central materiel supply.
    - Loading and unloading of the sterilizer.
    - Sterilization process monitoring.
    - Shelf life of sterile items (*to include labeling*).
    - Tray setup and wrapping procedures (*to include cleaning and preparing equipment supplies for sterilization*).
- Nursing service.
    - Nursing documentation.

- Scope of nursing practices.
- Standards of nursing practices.
- Standards of patient care.
- Assignment of personnel.
- Special category of personnel.
- Infection control.
- Procedures available in radiology.
- Procedures available in the medical laboratory.
- Admission and discharge procedures.
- Procedures for cardiopulmonary resuscitation.
- Mass casualty plan.
- Preoperative care of patients.
- Postoperative care of patients.
- Care of patients with indwelling catheters.
- Care of patients with central IV lines.
- Care of patients with tracheostomies.
- Care of patients with chest tubes.
- Death procedures.
- Ambulatory care procedures.
- Mass casualty procedures (*plan and training requirements; medical cadre positions and duties; nonmedical personnel positions and duties, including litter teams and perimeter guard, crowd control, and information personnel; location of services* [*to include triage, DELAYED, IMMEDIATE, MINIMAL, and EXPECTANT care areas*]).

- Medical equipment repair and maintenance.
- Maintenance request procedures.

- Scheduled maintenance.
- Receipt of new equipment.
- Requisitioning of repair parts.

- Veterinary services.
  - Care of government-owned animals.
  - Food inspection.
  - Zoonotic disease surveillance and control.
  - Protocol for postexposure rabies prophylaxis.
  - Humanitarian assistance missions.
- Preventive medicine services.
  - Theater DNBI surveillance program.
  - Food service sanitation.
  - Foodborne illness outbreak investigation.
  - Water quality surveillance.
  - Climatic injury prevention.
  - Entomology and pest control.
  - Humanitarian assistance programs.
  - Disaster relief coordination.
  - Sexually transmitted diseases prevention and control (*to include the human immunodeficiency virus*).
  - Infectious disease reporting.
  - Field sanitation team training.
  - Radiation and NBC protection.

- Radiology services.
    - Exposure area.
    - Darkroom.
    - Infection control.
    - File room.
    - Untoward reaction to contrast material procedures.
    - Emergency drug tray.
    - Disposition of used needles and syringes.
    - Security.
    - Dealing with the critically ill inpatient.
    - Radiation safety rules for nonradiology personnel.
    - Radiation protection in diagnostic radiologic examinations.
    - Shielding of patient and technician.
    - Recovery of silver.
    - Electrical and mechanical safety rules.
    - Routine radiographic views.
    - Weekly processor tests.
    - Quality control procedures.
    - Filing procedures.
- Emergency medical treatment.
    - Functions.
    - Scope of practice of MOS 91B personnel.
    - Scope of practice of MOS 91C personnel.

- Mass casualty operations.
- Medical evacuation procedures.
- Blood alcohol testing.
- Animal bites.
- Protocol for postexposure rabies prophylaxis.
- Preexposure rabies prophylaxis.
- Sexually transmitted diseases.
- Reporting of unusual occurrences.
- Routine care of HN military and dependents.
- Specialty clinics for HN civilians.
- Preemployment physicals for HN civilian employees.
- Routine medical care for HN contract civilian employees.
- Medical treatment for BW and CW agent casualties.

- Medical rapid response team.
  - Threat information.
  - Organization and functions.
  - Deployment of team (*to include coordination with HN, if applicable*).
  - Medical equipment and supplies.
  - Command, control, and communications.
  - Geneva Conventions.
  - Tasking organizations (*to include medical element, aviation element, and military police element*).
  - Intelligence requirements and signal operating instructions.
  - Bomb discovery and disposal augmentation, if appropriate.

(3) Medical readiness training exercises.

- Definition and scope.
- Employment and deployment.
- Coordinator responsibilities.
- Mission planning and execution.
- Equipment and supply requirements.
- Duration of exercise.
- Medical mission reconnaissance checklist.
- Accounting.
- After-action reporting requirements and special distribution.

(4) Medical supply and maintenance.

- Stockage levels (*to include rotation of stock*).
- Procedures for resupply (*to include time lines*).
- Coordination requirements.
- Procedures for medical maintenance (*organic and depot*).

(5) General supply and maintenance.

- Stockage levels.
- Procedures for resupply (*to include time lines*).
- Coordination requirements.
- Procedures for organic and depot maintenance and repair.

GLOSSARY

ABBREVIATIONS, ACRONYMS, AND DEFINITIONS

A2C2 Army airspace command and control

AAR after-action report

ABLS Advanced Burn Life Support

ACLS Advanced Cardiac Life Support

AFMIC Armed Forces Medical Intelligence Center

AIT Aeromedical Isolation Team

AMEDD Army Medical Department

AMEDDC&S Army Medical Department Center and School

AML area medical laboratory

antiterrorism Defensive measures used to reduce the vulnerability of individuals and property to terrorist acts to include limited response and containment by local military forces.

AO area of operations

AOR area of responsibility

AR Army Regulation

ARC American Red Cross

ARSOF Army special operations forces

ASMB area support medical battalion

ASMC area support medical company

ATM advanced trauma management

attn attention

AXP ambulance exchange point

BAS battalion aid station

BF battle fatigue

bio biological

BW biological warfare

C2 command and control

C3IC coalition coordination, communications, and integration center

C4I command, control, communications, computers, and intelligence

CA civil affairs

CBQRF Chemical Biological Quick Response Force

CH cargo helicopter

chem chemical

CHL combat health logistics

CHS combat health support

CINC Commander in Chief

civil affairs—(DOD) Those phases of the activities of a commander which embrace the relationship between the military forces and civil authorities and people in a friendly country or area or occupied country or area when military forces are present. Also called CA.

civil war A war between factions of the same country; there are five criteria for international recognition of this status: the contestants must control territory, have a functioning government, enjoy some foreign recognition, have identifiable regular armed forces, and engage in major military operations.

CMO civil-military operations

COA course of action

COM Chief of Mission

combatting terrorism—(DOD) Actions, including antiterrorism (defensive measures taken to reduce vulnerability to terrorist acts) and counterterrorism (offensive measures taken to prevent, deter, and respond to terrorism) taken to oppose terrorism throughout the entire threat spectrum.

CONUS continental United States

counterinsurgency—(DOD) Those military, paramilitary, political, economical, psychological, and civic actions taken by a government to defeat insurgency.

counterterrorism Offensive measures taken to prevent, deter, and respond to terrorism.

country team The executive committee of an embassy, headed by the Chief of Mission, and consisting of principal representatives of the government departments and agencies present (for example, the Departments of State, Defense, Treasury, Commerce, and the US Information Agency, US Agency for International Development, Drug Enforcement Agency, and Central Intelligence Agency).

crisis An incident or situation involving a threat to the United States, its territories, citizens, military forces, and possessions or vital interests that develop rapidly and create a condition of such diplomatic, economic, political, or military importance that commitment of US military forces and resources is contemplated to achieve national objectives.

CS combat support

CSC combat stress control

CSH combat support hospital

CSOP clinical standing operating procedure

CSS combat service support

CW chemical warfare

DA Department of the Army

DD/DOD Department of Defense

DE directed energy

DEA Drug Enforcement Agency

DHHS Department of Health and Human Services

DIA Defense Intelligence Agency

DNBI disease and nonbattle injuries

DOC Department of Commerce

DOD/DD Department of Defense

DOE Department of Energy

DOEd Department of Education

DOI Department of the Interior

DOJ Department of Justice

DOL Department of Labor

DOS Department of State

DOT Department of Transportation

DVA Department of Veteran Affairs

EAC echelons above corps

EMT emergency medical treatment

EPA Environmental Protection Agency

EPW enemy prisoners of war

ER emergency room

ESF emergency support function

evac evacuation

FDA Food and Drug Administration

FEMA Federal Emergency Management Agency

FH field hospital

FID foreign internal defense

FLOT forward line of own troops

FM field manual (when used with a number)/frequency modulated

FOB forward operating base

foreign internal defense—(DOD) Participation by civilian and military agencies of a government in any of the action programs taken by another government to free and protect its society from subversion, lawlessness, and insurgency. Also called FID.

foreign military sales—(DOD) That portion of United States security assistance authorized by the Foreign Assistance Act of 1961, as amended, and the Arms Export Control Act of 1976, as amended. This assistance differs from the Military Assistance Program and the International Military Education and Training Program in that the recipient provides reimbursement for defense articles and services transferred.

FRAGO fragmentary order

FRERP Federal Radiological Emergency Response Plan

FRP Federal Response Plan

FSMC forward support medical company

FST forward surgical team

GH general hospital

GP general purpose

GPMRC Global Patient Movement Requirements Center

GSA General Services Administration

guerrilla warfare—(DOD, NATO) military and paramilitary operations conducted in enemy held or hostile territory by irregular, predominantly indigenous forces. See also **unconventional warfare**.

HN host nation

host nation—(DOD, NATO) A nation which receives the forces and/or supplies of allied nations and/or NATO to be located on, or to operate in, or to transit through its territory.

humanitarian assistance Assistance provided by DOD forces, as directed by appropriate authority, in the aftermath of natural or man-made disasters to help reduce conditions that present a serious threat to life and property. Assistance provided by US forces is limited in scope and duration and is designed to supplement efforts of civilian authorities that have primary responsibility for providing such assistance.

ICU intensive care unit

IDAD internal defense and development

informational actions Communication with a foreign government, its supporters, its opponents, and others to explain one's own policies and actions.

infrastructure In an insurgency, the leadership organization and its system for command and control. In a broader sense, the systems of communications and the institutions which support the political and economic functions of a society.

insurgency—(DOD, NATO) An organized movement aimed at the overthrow of a constituted government through use of subversion and armed conflict.

interagency operations Any action that combines the human and material resources of two or more independent organizations, whether they are governmental, international, or private, in the prosecution of a common objective.

internal defense and development The full range of measures taken by a nation to promote its growth and protect itself from subversion, lawlessness, and insurgency. Also called the IDAD strategy.

interoperability—(DOD, NATO) The ability of systems, units, or forces to provide services to and accept services from other systems, units, or forces and to use the services so exchanged to enable them to operate effectively together.

ISB intermediate staging base

IV intravenous

J3 Operations Directorate

J5 Plans and Policy Directorate

JSOA joint special operations areas

JTF joint task force

LAB laboratory

LOC lines of communications

MASF mobile aeromedical staging facility

MAST military assistance to safety and traffic

MCBAT Medical Chem-Bio Advisory Team

MED medium

MEDCEN medical center

MEDCOM medical command

MEDDAC medical department activity

MES medical equipment set

METT-T mission, enemy, terrain, troops and time available

MH mental health

military assistance programs—(DOD) That portion of the US security assistance authorized by the Foreign Assistance Act of 1961, as amended, which provides defense articles and services to recipients on a nonreimbursable (grant) basis.

military civic action—(DOD) The use of preponderantly indigenous military forces on projects useful to the local population at all levels in such fields as education, training, public works, agriculture, transportation, communications, health, sanitation, and others contributing to economic and social development, which would also serve to improve the standing of the military forces with the population. (US forces may at times advise or engage in military civic actions in overseas areas.)

ml milliliter

MOPP mission-oriented protective posture

MOS military occupational specialty

MOUT military operations on urbanized terrain

MRE meals, ready to eat

MRI medical reengineering initiative

MRO medical regulating office

MSMC main support medical company

MTF medical treatment facility

MTT mobile training team

MWD military working dog

NATO North Atlantic Treaty Organization

NBC nuclear, biological, or chemical

NCA National Command Authorities

NCO noncommissioned officer

NCOIC noncommissioned officer-in-charge

NCS National Communications System

NDMS National Disaster Medical System

NEO noncombatant evacuation operations

NGO nongovernmental organization

no number

NP neuropsychiatric

NRC Nuclear Regulatory Commission

NWS National Weather Service

OCONUS outside the continental United States

ODA operational detachment "A"

OIC officer in charge

OMF originating medical facility

OPLAN operation plan

OPORD operation order

OPSEC operations security

OR operating room

OT occupational therapy

PA physician assistant

peacekeeping operations Military operations, conducted with the consent of the belligerent parties to a conflict, to maintain a negotiated truce and to facilitate diplomatic resolution of a conflict between the billigerents.

peacetime contingency operations Politically sensitive military operations normally characterized by the short-term, rapid projection or employment of forces in conditions short of war.

PL public law

PMM preventive medicine measures

POLAD political advisor

POM preparation for oversea movement

POR preparation of replacements for oversea movement

PREOP preoperative

psychological operations—(DOD) Planned operations to convey selected information and indicators to foreign audiences to influence their emotions, motives, objective reasoning, and ultimately the behavior of foreign governments, organizations, groups, and individuals. The purpose of psychological operations is to induce or reinforce attitudes and behavior favorable to the originator's objective. Also called PSYOP.

PSYOP psychological operations

PT physical therapy

pub publication

PVNTMED preventive medicine

PVO private volunteer organization

rationalization—(DOD) Any action that increases the effectiveness of allied forces through more efficient or effective use of defense resources committed to the alliance. Rationalization includes consolidation, reassignment of nation priorities to higher alliance needs, standardization, specialization, mutual support or improved interoperability, and greater cooperation. Rationalization applies to both weapons/materiel resources and nonweapons military matters.

RMC regional medical command

ROE rules of engagement

RTD return to duty

S2 Intelligence Officer (US Army)

SAO Security Assistance Organization

security assistance—(DOD) Groups of programs authorized by the Foreign Assistance Act of 1961, as amended, and the Arms Export Control Act of 1976, as amended, or other related statutes by which the US provides defense articles, military training, and other defense-related services, by grant, loan, credit, or cash sales in furtherance of national policies and objectives.

security assistance organization All DOD elements located in a foreign country with the responsibility for carrying out security assistance management functions. For example, military assistance advisory groups, military missions and groups, liaison groups, defense attache personnel, and other groups which perform security assistance functions. Also called SAO.

SF Special Forces

SFOB Special Forces operating base

SIMLM single integrated medical logistics manager

SO special operations

SOA special operations aviation

SOC special operations command

SOF special operations forces

SOP standing operating procedure

SOSB special operations support battalion

SOSCOM special operations support command

SR special reconnaissance

SRT specialty response team

standardization—(NATO) The process of developing concepts, doctrines, procedures, and designs to achieve and maintain the most effective levels of compatibility, interoperability, interchangeability, and commonality in the fields of operations, administration, and materiel.

TAML theater area medical laboratory

TAMMIS Theater Army Medical Management Information System

TBSA total body surface area

TC training circular

TDA table(s) of distribution and allowances

terrorism—(DOD) The unlawful use or threatened use of force or violence against individuals or property to coerce or intimidate governments or societies, often to achieve political, religious, or ideological objectives.

TF task force

TM technical manual

TO theater of operations

TOE table(s) of organization and equipment

TPMRC Theater Patient Movement Requirements Center

TSOP tactical standing operating procedure

UH utility helicopter

UN United Nations

unconventional warfare—(DOD) A broad spectrum of military and paramilitary operations conducted in an enemy-held, enemy-controlled, or politically sensitive territory. Unconventional warfare includes, but is not limited to, the interrelated fields of guerrilla warfare, evasion and escape, subversion, sabotage, and other operations of a low visibility, covert, or clandestine nature. These interrelated aspects of unconventional warfare may be prosecuted singly or collectively by predominantly indigenous personnel, usually supported and directed in varying degrees by (an) external sources during all conditions of war or peace. Also called UW.

US United States

USACHPPM United States Army Center for Health Promotion and Preventive Medicine

USAF United States Air Force

USAID United States Agency for International Development

USAISR United States Army Institute of Surgical Research

USAMEDCOM United States Army Medical Command

USAMRIID United States Army Medical Research Institute of Infectious Diseases

USAMRMC United States Army Medical Research and Materiel Command

USAR United States Army Reserve

USAVETCOM United States Army Veterinary Command

USCS United States Customs Service

USDA United States Department of Agriculture

USFS United States Forest Service

USN United States Navy

USPHS United States Public Health Service

USSOCOM United States Special Operations Command

UW unconventional warfare

UWOA unconventional warfare operations area

WHO World Health Organization

WIA wounded in action

REFERENCES

SOURCES USED

These are the sources quoted or paraphrased in this publication.

Joint and Multiservice Publications

DOD 6420.1-R. *Organization and Functions of the Armed Forces Medical Intelligence Center (AFMIC)*. 25 April 1986.
Joint Pub 1-02. *Department of Defense Dictionary of Military and Associated Terms.* 23 March 1994.
Joint Pub 3-0. *Doctrine for Joint Operations.* 1 February 1995.
Joint Pub 3-07. *Joint Doctrine for Military Operations Other Than War.* 16 June 1995.
Joint Pub 3-07.1. *Joint Tactics, Techniques, and Procedures for Foreign Internal Defense*. 26 June 1996.
Joint Pub 3-07.4. *Joint Counterdrug Operations.* 9 August 1994.
FM 8-285. *Treatment of Chemical Agent Casualties and Conventional Military Chemical Injuries.* NAVMED P-5041; AFJMAN 44-149; FMFM 11-11. 22 December 1995.
FM 3-3-1. *Nuclear Contamination Avoidance.* FMFM 11-18. 9 September 1994.
FM 100-19. *Domestic Support Operations.* FMFM 7-10. 1 July 1993.
FM 100-20. *Military Operations in Low Intensity Conflict*. AFP 3-20. 5 December 1990.

Army Publications

FM 8-10-3. *Division Medical Operations Center—Tactics, Techniques, and Procedures.* 12 November 1996.
FM 100-23. *Peace Operations.* 30 December 1994.

DOCUMENTS NEEDED

These documents must be available to the intended users of this publication.

Code of Federal Regulations

Title 10, United States Code.

Joint and Multiservice Publications

*Joint Pub 3-05.3. *Joint Special Operations Operational Procedures.* 25 August 1993.
*Joint Pub 3-07.2. *Joint Tactics, Techniques, and Procedures for Antiterrorism.* 25 June 1993.
*Joint Pub 3-07.3. *Joint Tactics, Techniques, and Procedures for Peacekeeping Operations.* 29 April 1994.
*Joint Pub 4-02. *Doctrine for Health Service Support in Joint Operations.* 26 April 1995.

*This source was also used to develop this publication.

DA Pamphlet 40-3. *Medical Service Multilingual Phrase Book*. 31 May 1971. NAVMED P-5104; AFP 160-28.
*FM 3-3. *Chemical and Biological Contamination Avoidance*. FMFM 11-17. 16 November 1992.
*FM 8-9. *NATO Handbook on the Medical Aspects of NBC Defensive Operations AMedP-6(B), Part I—Nuclear, Part II—Biological, Part III—Chemical*. NAVMED P-5059; AFJMAN 44-151V1V2V3. 1 February 1996.
*FM 8-33. *Control of Communicable Diseases Manual (16th Edition)*. NAVMED P-5038. 9 April 1996.
TM 5-632. *Military Entomology Operational Handbook*. NAVFAC MO-310; AFM 9-16. 1 December 1971. (Reprinted with basic including Changes 1—2, January 1976.)

Army Publications

AR 40-3. *Medical, Dental, and Veterinary Care.* 15 February 1985. (Latest Change 3 November 1995).
AR 40-5. *Preventive Medicine*. 15 October 1990.
AR 40-35. *Preventive Dentistry.* 26 March 1989.
AR 40-48. *Nonphysican Health Care Providers.* 1 August 1995.
AR 40-61. *Medical Logistics Policies and Procedures*. 25 January 1995.
AR 40-66. *Medical Record Administration*. 20 July 1992.
AR 40-400. *Patient Administration*. 1 October 1983.
FM 8-10. *Health Service Support in a Theater of Operations*. 1 March 1991.
*FM 8-10-1. *The Medical Company—Tactics, Techniques, and Procedures.* 29 December 1994.
FM 8-10-4. *Medical Platoon Leaders' Handbook—Tactics, Techniques, and Procedures*. 16 November 1990.
*FM 8-10-6. *Medical Evacuation in a Theater of Operations—Tactics, Techniques, and Procedures*. 31 October 1991. (Change 1, 8 March 1994.)
*FM 8-10-7. *Health Service Support in a Nuclear, Biological, and Chemical Environment*. 22 April 1993. (Change 1, 26 November 1996.)
*FM 8-10-8. *Medical Intelligence in a Theater of Operations*. 7 July 1989.
FM 8-10-9. *Combat Health Logistics in a Theater of Operations—Tactics, Techniques, and Procedures.* 3 October 1995.
*FM 8-10-18. *Veterinary Service—Tactics, Techniques, and Procedures.* Print date: 22 August 1997.
*FM 8-10-19. *Dental Service Support in a Theater of Operations*. 12 May 1993.
*FM 8-51. *Combat Stress Control in a Theater of Operations—Tactics, Techniques, and Procedures.* 29 September 1994.
*FM 8-55. *Planning for Health Service Support*. 9 September 1994.
FM 8-250. *Preventive Medicine Specialist*. 27 January 1986. (Reprinted with basic including Change 1, 12 September 1986.)
FM 8-505. *Army Medical Field Feeding Operations.* 10 November 1989.
FM 10-52. *Water Supply in Theaters of Operations.* 11 July 1990.
FM 21-10. *Field Hygiene and Sanitation*. 22 November 1988.
FM 21-10-1. *Unit Field Sanitation Team*. 11 October 1989.
*FM 22-51. *Leaders' Manual for Combat Stress Control*. 29 September 1994.
FM 27-10. *The Law of Land Warfare*. 18 July 1956. (Reprinted with basic including Change 1, 15 July 1976.)

FM 63-6. *Combat Service Support in Low-Intensity Conflict*. 21 January 1992.
*FM 90-10 (HTF). *Military Operations on Urbanized Terrain (MOUT) (How to Fight)*. 15 August 1979.
*FM 90-10-1. *An Infantryman's Guide to Combat in Built-up Areas*. 12 May 1993. (Change 1, 3 October 1995.)
*FM 100-5. *Operations*. 14 June 1993.
FM 100-17-1. *Army Pre-Positioned Afloat Operations*. 27 July 1996.
TC 5-400. *Unit Leaders' Handbook for Environmental Stewardship*. 29 September 1994. (Reprinted with basic including Change 1, 3 October 1995.)

DEPARTMENT OF DEFENSE FORMS

DD Form 600. *Patient's Baggage Tag*. 1 July 1973.
DD Form 601. *Patient Evacuation Manifest*. 1 October 1951.
DD Form 602. *Patient Evacuation Tag*. 1 February 1963.

DEPARTMENT OF THE ARMY FORM

DA Form 2028. *Recommended Changes to Publications and Blank Forms*. 1 February 1974.

READINGS RECOMMENDED

These readings contain relevant supplemental information.

North Atlantic Treaty Organization Standardization Agreements (STANAGs)

2002. *Warning Signs for the Marking of Contaminated or Dangerous Land Areas, Complete Equipments Supplied and Stores. 26 November 1980. (Latest Amendment, 12 December 1989.)*
2027. *Marking of Military Vehicles*. 18 December 1975. (Latest Amendment, 22 November 1988.)
2040. *Stretchers, Bearing Brackets, and Attachment Supports*. 23 September 1982. (Latest Amendment, 30 May 1986.)
2068. *Emergency War Surgery.* 28 October 1986. (Latest Amendment, 30 January 1990.)
2087. *Medical Employment of Air Transport in the Forward Area.* 29 June 1983. (Latest Amendment, 30 April 1990.)
2128. *Medical and Dental Supply Procedures*. 15 November 1982. (Latest Amendment, 31 August 1988.)
2132. *Documentation Relative to Medical Evacuation, Treatment, and Cause of Death of Patients*. 7 August 1974. (Latest Amendment, 15 September 1986.)
2135. *Procedures for Emergency Logistics Assistance.* 12 February 1982. (Latest Amendment, 5 December 1986.)
2358. *First-Aid and Hygiene Training in NBC Operations.* 3 March 1989. (Latest Amendment, 26 April 1994.)
2500. *NATO Handbook on the Medical Aspects of NBC Defensive Operations—AMedP-6(A) (Edition 3)*. 23 December 1987.

2871. *First-Aid Materiel for Chemical Injuries*. 8 March 1989. (Latest Amendment, 24 July 1995.)
2873. *Concept of Operations of Medical Support in Nuclear, Biological, and Chemical Environments—AMedP-7(A)*. 31 August 1982.
2874. *Planning Guide for the Estimation of Battle Casualties (Nuclear)—AMedP-8*. 27 November 1981. (Latest Amendment, 13 September 1985.)
2879. *Principles of Medical Policy in the Management of a Mass Casualty Situation*. 17 June 1986. (Latest Amendment, 25 March 1995.)
2931. *Orders for the Camouflage of the Geneva Emblem and Red Crescent on Land in Tactical Operations*. 18 October 1984. (Latest Amendment, 8 August 1988.)
2939. *Medical Requirements for Blood, Blood Donors, and Associated Equipment*. 2 June 1987. (Latest Amendment, 23 November 1987.)
3204. *Aeromedical Evacuation*. 26 September 1973. (Latest Amendment, 23 June 1989.)

Quadripartite Standardization Agreements (QSTAGs)

201. *ABCA Table of Medical Equivalents of Medical Materiel (Edition 2)*. 26 March 1981.
230. *Morphia Dosage Agreement (Edition 2)*. 23 January 1985.
236. *Medical Gas Cylinders*. 8 April 1971. (Latest Amendment, 18 June 1984.)
245. *Minimum Requirements for Water Potability (Short and Long Term Use) (Edition 2)*. 10 September 1985.
248. *Identification of Medical Materiel to Meet Urgent Needs*. 7 December 1973. (Latest Amendment, 20 September 1976.)
287. *Procedure for Reporting and Initial Disposition of Unsatisfactory Medical Materiel (Edition 3)*. 15 July 1987.
288. *Intravenous Replacement Fluids*. 13 August 1980. (Latest Amendment, December 1987.)
289. *Minimum Essential Characteristics of Blood Products Shipping Containers (Edition 3)*. 12 August 1991.
290. *Minimum Requirements for Controlled Temperature Storage and Transport of Medical Materiel (Edition 2)*. 16 February 1989.
291. *Interface of Medical Materiel Procedures*. 5 June 1974.
292. *Vaccination of Armed Forces (Edition 2)*. 6 August 1984. (Latest Amendment, 9 December 1985.)
322. *Emergency War Surgery*. 19 November 1973. (Latest Amendment, 8 August 1988.)
343. *Basic Requirements for Electronic Surveillance of Patients in the Field*. 7 May 1975. (Latest Amendment 9, August 1976.)
344. *Basic Voltage and Current Characteristics of Electro-Medical Equipment*. 7 May 1975. (Latest Amendment, 21 December 1984.)
345. *Essential Characteristics of High Pressure Steam Sterilizers*. 20 June 1975. (Latest Amendment, 20 June 1984.)
423. *Equation of Medical Facilities in the Field (Edition 3)*. 24 October 1991.
433. *Essential Performance Characteristics of Field Surgical Lights*. 28 June 1977. (Latest Amendment, 1 June 1984).
434. *Patient and Operator Protection from Failure of Electromedical Equipment*. 23 January 1985.
470. *Documentation Relative to Medical Evacuation, Treatment, and Cause of Death of Patients*. 23 February 1979. (Latest Amendment, 10 April 1988.)

512. *Marking of Military Vehicles*. 31 January 1979. (Latest Amendment, 2 May 1983.)
519. *Stretchers*. 20 November 1985.
529. *Medical Employment of Air Transport in the Forward Area*. 24 March 1980. (Latest Amendment, 9 December 1985.)
535. *Medical Training in First-Aid, Basic Hygiene, and Emergency Care*. 12 November 1979. (Latest Amendment, 9 December 1985.)
536. *Medical, Surgical, and Dental Instruments, Equipment, and Supplies*. 17 January 1980.
622. *Essential Characteristics of Surgical Instruments*. 9 August 1979.
623. *Standard Method of Writing Prescriptions for Spectacles*. 9 August 1979.
624. *Medical Design Requirements for Military Motor Ambulances*. 23 August 1984.
677. *Resuscitation Materiel for Field Use (Edition 2)*. 12 August 1991.
815. *Blood Supply in the Area of Operations*. 25 October 1991.
816. *Medical Aspects of Mass Casualty Situations*. 25 June 1987.
850. *Blood, Blood Donor, and Transfusion Equipment Requirements (Edition 2)*. 16 February 1989.
889. *Essential Field Sanitary Requirements (Edition 1)*. 27 September 1988.
892. *Prevention of Cold Injury*. 21 October 1991.
893. *Patient Management in a Cold Climate*. 21 October 1991.
908. *Medical Warning Tag*. 16 February 1989.
909. *Principles of Prevention and Management of Combat Stress Reaction*. 21 October 1991.
977. *Medical Regulating*. 21 October 1991.

Joint and Multiservice Publications

AR 40-535. *Worldwide Aeromedical Evacuation*. AFR 164-5; OPNAVINST 4630.9C; MCO P-4630.9A. 1 December 1975. (Reprinted with basic including Change 1, 10 May 1979.)
AR 40-562. *Immunizations and Chemoprophylaxis*. AFJI 48-110; BUMEDINST 6230-15; CG COMDTINST M6230.4E. 1 November 1995.
FM 3-4. *NBC Protection*. FMFM 11-9. 29 May 1992. (Change 2, 21 February 1996.)
FM 3-5. *NBC Decontamination*. FMFM 11-10. 17 November 1993.
FM 3-100. *Chemical Operations—Principles and Fundamentals*. MCWP 3-3.7.1. 8 May 1996.
FM 90-3. *Desert Operations*. FMFM 7-27. 24 August 1993.
FM 100-27. *United States Army/United States Air Force Doctrine for Joint Airborne and Tactical Airlift Operations*. AFM 2-50. 31 January 1985. (Reprinted with basic including Change 1, 29 March 1985.)

Air Standards

44/36A. *Aeromedical Evacuation by Helicopter*. 2 October 1978.
61/71. *Selection, Priorities, and Classes of Conditions for Aeromedical Evacuation*. 10 May 1989.

Army Publications

DA Pamphlet 27-1. *Treaties Governing Land Warfare*. 7 December 1956.

FM 1-120. *Army Air Traffic Services Contingency and Combat Zone Operations*. 22 May 1995.
FM 19-15. *Civil Disturbances*. 25 November 1985.
FM 19-30. *Physical Security*. 1 March 1979.
FM 19-40. *Enemy Prisoners of War, Civilian Internees, and Detained Persons*. 27 February 1976.
FM 21-11. *First Aid for Soldiers*. 27 October 1988. (Change 2, December 1991.)
FM 21-76. *Survival*. 5 June 1992.
FM 27-2. *Your Conduct in Combat Under the Law of War.* 23 November 1984.
FM 31-20. *Doctrine for Special Forces Operations*. 20 April 1990.
FM 41-10. *Civil Affairs Operations*. 11 January 1993.
FM 90-5 (HTF). *Jungle Operations (How to Fight)*. 16 August 1982.
FM 90-6. *Mountain Operations*. 30 June 1980.
FM 90-8. *Counterguerrilla Operations*. 29 August 1986.
FM 90-29. *Noncombatant Evacuation Operations*. 17 October 1994.
FM 100-10. *Combat Service Support*. 3 October 1995.
FM 100-26. *The Air-Ground Operations System*. 30 March 1973.
FM 100-103. *Army Airspace Command and Control in a Combat Zone*. 7 October 1987.

INDEX

References are to paragraph numbers except where specified otherwise.

advanced trauma management, 2-3*a*, 4-7, I-9, N-7*a*, N-21*c*
Aeromedical Isolation Team, I-12*d*
American Public Health Association, 1-5*b*(1)
American Red Cross, B-3*a*
antiterrorism. *See* combatting terrorism.
area support medical company/battalion, 2-3*a*, 4-16*d*
Armed Forces Medical Intelligence Center, 1-5*b*(1*)*, 3-6*a*(1), 3-11*a*(4), I-11*c*, N-13
armored cavalry regiment, 2-3*a*
Army airspace command and control, 2-4*e*
Army Medical Department. *See also* peace support operations.
  assets, Appendix O
  battlefield rules, 1-9. *See also* medical (patient) evacuation.
  community assistance, 3-3*b*
  medical professionals, 4-6
  objective, 2-1*b*
  telemedicine, I-14*d*
  traditional role, 1-2*b*
assessments. *See also* dental; medical intelligence; medical threat; risk assessment.
  checklist, 3-6*a*(4)
  combat health logistics, 4-19*d*
  combat health support, 1-5*a*(3)
  combatting terrorism, 3-8*a*(1)
  commander's, C-6*g*
  disaster relief/assistance, 3-3*a*(3), 3-4*a*(2), 4-6*b*(3), 4-19*b*(1), K-1*a*
  factors, 3-11*b*(4)
  host nation needs, 3-4
  medical mission reconnaissance checklist, 3-6*a*(4), M-1—M-2
  mental health, 2-9, I-13*a*
  needs of a host nation military, 3-11*b*(4), 4-10*g*(1)(*a*)
  nuclear, biological, and chemical threat, G-1*b*
  preventive medicine, 4-10*h*
  security, A-3
  specialty response teams, I-9*a*, I-11*b*
  veterinary support, 4-12
Assistant Secretary of Health, 3-3*a*(1)
attacks and raids, 3-12, 4-7, 4-10*h*, 4-19*f*
battalion aid station, 2-3*a*, C-6*h*
biological warfare agent, 1-5*b*(2) and *e*, 4-21*a*, G-1—G-2, I-12*b*
blood management. *See* combat health logistics.
Brooke Army Medical Center, I-10*a*
Centers for Disease Control, 1-5*b*(1), 4-21*b*, I-11*c*
chain of command, 4-1
chemical warfare agent, 1-5*b*(2) and *e,* 2-2*a*, G-1, G-3, G-5, I-12*b*
civil affairs, 3-6, E-1, N-6*d*, N-7*e*

civilian
assets, 3-3*b*
casualties, 3-9*b*(3), 3-11*a*(4), 3-12*b*(5), 4-6*b*(2)
community, 1-7*b*, K-4*b*
contractors, 1-6*a*
educational status, 3-6*a*(3)
hospitals, 3-3*a*(3), 4-4*b*(1) and *d*, 4-6*b*(3), K-3*a*
host nation, 1-6*a,* 1-7*b*, 4-2*d*
medical infrastructure, K-3*c*
medical programs, 1-2*b*, 3-3*b*, 3-4
medical threat, 3-12*b*(1)
population, 3-6*a*(3), 3-12*b*(5)(*c*), 4-10*g*
preventive medicine support, 4-10*f*
recipients/beneficiaries of care, 1-1, 1-6*a*, 4-2*d*, 4-7*b*(2) and *f*(1)
refugees, 3-4, 3-12*b*(5), 4-16*c*
United Nations personnel, 1-6*a*
United States Government employees, 1-6*a*
combat health logistics. *See also* assessments; training.
accounting for, 4-19*b*
augmentation of medical equipment sets, 3-3*a*(3), 4-19*a*
availability, 3-12*b*(5)(*c*), 4-19
basic load, N-16
blood management, 1-7*b*, 2-7*a,* 4-19, D-6*a*
captured (abandoned) medical materiel, 1-7*b*
combat health support plan, F-14
command surgeon responsibility, 1-7*b*, 4-18*c*
contracting for, 1-4*b*
coordination for, 2-7*a*, 4-18*b*, 4-19
critical item list, 2-7*a*
days of supply, 2-7*a*, 4-7*a*(2)
delivery of, 4-19
donated materials, 3-3*a*(3), 4-19
estimate, F-7
eyewear fabrication, 2-7*a*, 4-6*f*, 4-19*d*(2), N-16
factors, 4-19*b*(3)
foreign internal defense, 3-11*b*(3)
formulary, 4-19*d*(1)
host nation military needs, 3-11*b*(4)
infrastructure, 4-19*d*
line item requisition, 2-7*a*
maintenance and repair of equipment, 1-4*b*, 2-7*a*, 4-19, N-16
medical
equipment, 3-2*c*, 3-3*a*(3), 3-12*b*(5)(*a*), 4-15*b*(2), 4-19, N-16, N-21*b*
equipment sets, 3-3*a*(3), 3-11*b*(4), 4-19*a*, C-6*k*
logistics battalion, 2-7*a*, N-16

combat health logistics
medical (*continued*)
supplies, 3-2*c,* 3-8*d*(2), C-6*h*, N-16
waste, 4-18*c*
push packages, 2-7*a*, 4-19*f*
requirements, 1-7*b*, 3-9*b*(3), 4-18*b*, 4-19
resupply, 2-7*a*, 3-3*a*(3), 4-19*f*, C-6*h*
Single Integrated Medical Logistics Manager, 2-7*b*, 4-18*d*
special operations forces, N-7*a*(3), N-16
stockage levels, 3-12*b*(5)(*a*), 4-19*d*(1)
tactical standing operating procedures, P-1*a*, P-6
traditional support, 4-19*e*
veterinary drugs and equipment, 4-11*d*
combat health support
alternate sources, 3-9*a*(3)(*b*)
area medical support, Chapter 4, D-6*f*
augmentation, 3-8*d*(2), 3-9*a*(3)(*a*), 4-7*g*
commander, 1-3*a*(1)*,* 1-6*b*, 1-7*b*, 3-8*d*(1), 4-1, 4-9*c*(6), 4-18*c*, A-2, A-4*b*
cornerstones, 1-6*a*
definition in stability and support operations, 1-2*b*
degraded services, 3-12*b*(5)(*c*)
doctrine, Preface
duplication of services, 1-4*c*, 3-10*b*(2), B-6
element, 4-6, P-1*b*—*c*, P-4
end state, 1-3*a*(1), B-6, K-3*c*
estimate, 1-7*b*, F-1—F-7
for host nation military, 3-5*c*
insurgency, 3-11
legitimacy, 1-3*a*(3)
limitations, 3-9*a*(3)
military intervention, 1-3*a*(3)(*b*)
mission, 3-12*b*, 4-1
outside the continental United States, 1-5*c,* 1-8*a*(2), P-4*a*
programs, 1-3*a*(3), 1-6*a,* 1-7*a*
provisions of, Preface, 1-1, 1-6
rear area protection, 1-7*b*
resources, 1-5*b*(2), 1-8*b*, 3-6*a*(2), 3-12*a*(1)
return to duty, 1-6*a*
traditional support, 1-1, 1-2*b,* 1-6*a*, 1-8*b*, 2-1*a*, 3-3*a*(3) and *d*, 3-8*c*, 3-10*b*, 4-7, F-1*a*
combat medic, 2-3*a*, 3-12*b*(4), 4-7*g*
combat service support, 1-1, 3-11, 3-12*b*, N-5*c*, N-8
combat stress. *See* mental health.
combat support, 3-11, 3-12*b,* A-4*b*, N-5*c*, N-8
combatting terrorism. *See also* mass casualties; veterinary services.
antiterrorism, 3-8*b*, A-2

combatting terrorism (*continued*)
coordination, 3-8*e*
countermeasures, 3-8*d*(2)
counterterrorism, 3-8*c*, N-18, N-21
definition, 3-8*a*(1)
estimate, A-3
force protection, A-2, A-4
general, 3-8*a*
identification of requirements, A-1
mental health activities, 4-17*c*
nuclear, biological, and chemical threat, 1-5*b* and *e*
orientation, 3-8*e*(2)
passive defense, A-1
planning considerations, 3-8*d*
publicity, A-2*a*
reduce vulnerability, 3-8, 3-9*a*(3)(*b*)
security equipment, 3-8*d*(2)
stress debriefings, 4-17*d*
support of, 3-3*d*
tactics, 3-8*a*(2)
targets, 3-8*d*(2), 4-7*e*, 4-9*c*(4)
terrorist activities, 1-3*a*(6), 4-16*c*, A-2*a*, A-4*c*, G-1, G-6, N-21*a*
terrorists, Preface, 1-5*e*, A-2, G-1, G-3—G-4, G-6
command surgeon. *See also* combat health logistics; medical (patient) evacuation; planning.
applicability, Preface
Army service component, 4-2*b*
assessment, 1-7*b*, 1-8*a*
availability of resources, 1-7*b*, 1-8*a*
Commander in Chief, 4-11*b*
coordination, 1-7*b*, 2-2*a*, 4-8
dental support, 1-7*b*, 4-14*b*
determining eligibility, 4-7*f*(1), D-5
determining health needs, 1-7, 3-6*a*(1)
duties and responsibilities, 1-7—1-8
enemy prisoners of war/detainees, 1-7*b*
flexibility, 1-8*b*
health of the command, 1-7*a*, 1-9*a*, G-2*b*
health status of the population, 1-8*a*(1)
joint surgeon, K-2*a*, K-4*a*
nation assistance, 3-6*a*(1)
personnel management/assignment, 1-7*b*
planning, 1-7, 1-8*b*, 3-6*a*(2), D-6
problem solving, 1-8
program implementation, 1-7*a*
providing oversight, 1-7*b*

command surgeon (*continued*)
research and development, 1-7*b*
role, 1-8
task organization, 4-9*c*(6)
theater, N-16
communications *See also* mass casualties.
ambulances, 3-3*a*(4)
commonality, 4-1
coordination, 3-3*a*(3), 4-2*c*
disaster relief, 3-3*a*(3), K-2*b*
interoperability/commonality, 4-1, D-4*a*, D-6*a*
liaison, 4-2*a*
medical regulating, D-6*a*
messenger system, 3-3*a*(4)
contingency plans
disaster relief/assistance, K-1*a*
general, 2-2*a*
mass casualty situation, 3-8*e*(1), 4-7*e*
peace support operations, 3-9*a*(3)(*b*)
counterdrug operations. *See also* medical (patient) evacuation; veterinary services.
mission, 1-6*c*
support to, 3-3*d*, 3-7, 3-12, 4-7, 4-12*d*, B-3*a*
counterinsurgency. *See also* dental support; veterinary services: support for insurgency and counterinsurgency.
definition, 3-11*b*
developmental programs, 3-11*b*(1)
health issues, 3-11*b*(1)
internal defense and development, 3-11*b*(1)
legitimacy, 3-11*b*(1)
long-term commitment, 3-11*b*(3), 4-12*g*(3)(*d*)
mental health, 4-17*c*
mission, 1-6*c*
preventive medicine support, 4-10*g*
quality of life issues, 3-11*b*(1)
quick fix, 3-6*b*, 3-11*b*(3), 4-12*g*(3)(*c*)
veterinary support, 4-12*g*(2)
counterterrorism. *See also* combatting terrorism.
country team, 3-6, 3-11*b*(3), 4-12*g*(3), B-4*b*, B-5
courses of action, 1-8*b,* 4-12*a*(5)
credentialing, 4-2*d*, B-6, D-6*b*
defense
attaché, 3-6*a*
of patients, 1-3*a*(6)
of self, 1-3*a*(6)
dental. *See also* command surgeon.
assessment, 1-5*b*(2), 3-6*a*(3), 4-14*a—b*

dental (*continued*)
care, I-5*b*(2)
civil-military operations, 4-10*g*(2)(*c*)
combat health support plan, F-12
coordination for, 1-7*b*
disaster relief, 3-3*a*(3)
disease, 4-15
domestic support operations, 4-15*a*
estimate, F-5
foreign humanitarian assistance, 4-13*a*
foreign internal defense, 3-5*c*
foreign internal defense augmentation forces, 3-5*c*
forensic dental operations, 4-15*b*(1)
health, 3-6*a*(3)
health care needs, 4-14*a*
host nation military, 3-11*b*(4), 4-15*b*(1)
in conjunction with, 4-15*b*
infrastructure, 4-15*b*
insurgency, 4-14*c*
maxillofacial injuries, 3-3*a*(3), 4-15*b*, J-3*b*(2)
multinational operations, D-6*e*
planning, 4-14*c*
programs, 3-11*a*(4), 4-14*d*, 4-15*a*
public health officer, 1-5*b*(2), 4-14*a*
requirements, 4-14*b*
resources, 4-15*b*(2)
special operations forces, N-7*a*(1), N-17
standards of care, 4-14*b*, 4-15*b*(3)
status, 2-2*a*
surgeon, 1-7*b*
tactical standing operating procedures, P-6*k*(2)
traditional support, 4-13*a*, 4-15*c*
Department of
Agriculture, 4-12*g*(3), B-3*a*
Commerce, B-3*a*
Defense
agencies, B-1*a*, I-3*a*
disaster relief, 4-4*d*
domestic support operations, 4-4*b*
executive agency, 4-18*d*
foreign internal defense, N-20*a*
Institute of Chemical Defense, I-12
Intelligence Agency, N-13
special operations forces, N-1
veterinary support, 2-8, 4-12

Department of (*continued*)
Education, B-3*a*
Energy, B-3*a*
Health and Human Services, 3-3*a*(1), B-3*a*
Interior, B-3*a*
Justice, B-3*a*
Labor, B-3*a*
State
coordination with, 4-10*c*, 4-12*g*(3), B-4*a*
cultural exchange program, 3-5*b*
disaster relief, 4-10*c*
general, B-1*a*, I-3*a*
operations outside the United States, B-4
political advisor, B-4*b*
Secretary of, B-4*b*
Transportation, B-3*a*
Treasury, B-3*a*
Veterans Affairs, 4-4*d*
deployment
administrative preparation, 2-2*a*
availability, 3-5*c*
checklist, H-1—H-2
family care plan, 2-2*a*
mascot policy, 4-12*h*
security, 3-8*d*(2)
short notice, 2-2*a*, 4-12*c*
to area of operations, M-1*b*
transportation, C-6*n*
dietitians. *See* nonphysician health care practitioners.
disaster relief/assistance. *See also* assessments; planning.
administrative support, 4-2*b*, K-2
availability of resources, 3-3*a*(3)
caregivers, 4-12*b*
coordination and control, 3-3*a*(3)
eligibility for care, 3-3*a*(2), 4-2*d*
evacuation platform, 4-4*c*
man-made or natural, 3-3*a*(1), 3-4, 4-9*b*(3), 4-10*b*(1), 4-15*a*, 4-16*c*, K-4*a*
medical evacuation, 4-4*d*, K-3*a*
medical threat, 3-3*a*
military headquarters, 3-3*a*(3)
military retirees and families, 3-3*a*(2)
mission, 1-6*c*
nutrition, 4-6*b*(3)
plan, K-1*a*
rescuers, 3-3*a*(2), 4-2*d*, 4-12*b*

disaster relief/assistance (*continued*)
status board, K-4
support provided, 3-3*a*(2)
task list, K-4
types of diseases and injuries, 3-3*a*(3)
victims, 1-6*a*, 1-8*a*, 3-4*a*(1), 4-2*d*, 4-7*b*(1), 4-12*b*, J-2—J-3, J-5*a*(1)
withdrawal of support, K-3*c*
Disease Occurrence Worldwide, 1-5
diseases and injuries
arthropodborne, 4-9*b*(1)
cold injuries, 4-9*d*(2)
dental, 4-15*b*
disaster relief, 3-3*a*(3), 3-4*a*(1)
disease reporting, G-2*c*
disease surveillance, 3-4*b*
disease vectors, 3-4*b*, 4-9*b*(2), 4-10, I-5*b*(1), K-3*a*
endemic diseases, 2-6, 3-3*a*(3), 3-12*b*(1), 4-9*b*(2)(*a*), 4-10*h*, C-6*i*, D-5*d*, D-6*d*
environmental injuries, 3-12*a*(3), 4-8*a*, 4-10*e*
epidemic diseases, 2-6, 3-3*a*(3), C-6*i*
epidemiologic information, 4-10*b*(1)
heat injuries, 3-12*a*(3), 4-9*d*(1)
in developing nations, 1-7*b*
industrial hazards, 4-9*d*(3)
infectious diseases, 1-5*h,* 4-9*a*(2)(*a*), G-2
low epidemiological levels, 1-6*a*, 3-3*a*(3)
military operations on urbanized terrain, 3-12*b*
nonbattle, 1-9*b*, 3-9*a*(3), 4-10*e—f*
noneffectiveness, 4-8*a*, 4-9*b*(2)(*a*)
occupational hazards, 4-9*d*(3)
outbreaks, 3-4*a*(2)
prevention, 3-4*a*(2)
treatment, G-2*d*
types of, 3-12*b*(1), 4-9*b*(3), J-2
zoonotic, 4-12*h*
domestic support operations. *See also* hospitalization; medical (patient) evacuation.
categories, 3-3
community assistance, 3-3, 3-3*b*, 4-10*b*(3), 4-15*a*, B-3*a*
dental, 4-15*a*
disaster assistance, 3-3*a*, 4-10*b*(1), B-3*a*, K-2
eligibility determination, 3-3*a*(2), 4-7*b*(2)
emergency support function, 3-3*a*(1)
environmental assistance, 3-3*c*, 4-10*b*(2)
general, 4-6
law enforcement support, 3-3*d*, B-3*a*
legal authority, 3-3*a*(1)

domestic support operations (*continued*)
preventive medicine, 4-10*b*
Public Law 93-288 (*Federal Response Plan)*, 3-3, K-1
reimbursement, 3-3*a*(2), 4-7*b*(2)
request for assistance, 3-3*a*(1)
urban search and rescue, 3-3*a*(1)
Drug Enforcement Agency, B-3*a*
echelons of medical care. *See also* medical evacuation.
Echelon I, 2-3*a*, D-6*f*, N-7, N-9
Echelon II, 2-3*a,* 2-4*c*, 4-20, D-6*f*, N-7, N-9, N-22*b*
Echelon III, 2-3*a*, 2-4*c*, N-7, N-9, N-15, N-22*b*
Echelon IV, 2-3*a,* 2-4*c*, N-7, N-9
echelons above corps, 2-3*a*
evacuated to, 2-4*c*
general, 2-3*a*, 4-3
in theater, 2-3*a*, 2-4*b*
embassy, 3-9*a*(3)(*b*), 4-7*a*(2)
emergency medical treatment, 2-3*a*, 3-11*a*(4), 4-7, I-8, N-21*c*
enemy prisoners of war, 1-7*b*, 3-9*b*(3), 3-11*a*(4), P-6*d*
environmental assistance, 3-3*c*
Environmental Protection Agency, B-3*a*
equipment and clothing, 2-2*a*, 3-12, 4-9*d*(2), I-6*b*
Federal
Emergency Management Agency, 3-3*a*, B-3*a*
Radiological Emergency Response Plan, B-3*a*
Federal Response Plan, 3-3, 4-4*b*(6), 4-21*c*, B-3*a*, K-1*a*
finance
dental, 4-14*d*
funding, D-5*b*
management, 1-7*b*
reimbursement, 3-3*a*(2), 3-6*b*(4), 4-2*d*, 4-4*b*(3), 4-7*b*(2), B-6
first aid
buddy aid, 2-3*a,* 3-11*b*(4), 3-12*b*(4), N-7*a*(1)
chemical agent casualty, G-3*d*
combat lifesaver, 2-3*a*, 3-11*b*(4), 3-12*b*(4), N-7*a*(1)
dressing, J-3*b*(3)
pouch, 4-19*f*
self-aid, 2-3*a*, 3-11*b*(4), 3-12*b*(4), N-7*a*(1)
training, 3-11*a*(4) and *b*(4), I-8*a*
Food and Drug Administration, N-16
foreign humanitarian assistance
assessment, 3-4*a*
civilian medical programs, 3-4*a*(1)
definition, 3-4
host nation support, 3-4*a*

foreign humanitarian assistance (*continued*)
military operations on urbanized terrain, 3-12*b*(5)
nutrition, 4-6*b*(2)
participants, 1-3*a*(2)
peace support operations, 3-9
press coverage, 3-11*b*(3)
programs, 4-6*a*(1)
support to, 3-4, 4-11*d*
victims, 1-6*a*, 3-4*a*(1)
foreign internal defense
augmentation forces, 3-5*c*
definition, 3-5*c*
goals and objectives, 3-11*b*(2)
mission, 3-5*c*
role of military combat health support, 3-11*b*(3)
security assistance organization, 3-5*c*
veterinary support, 4-12*g*
forward support medical company, J-5*b*
forward surgical team. *See* hospitalization.
functional areas
area medical support, Chapter 4
combat health logistics, 2-7, 4-18, 4-19*a*
combat stress control and mental health services, 2-9, 4-16—4-17,
command, control, communications, computers, and intelligence, 4-1— 4-2
dental, 4-13*a*, 4-14—4-15
general, 3-5*c*, B-6, N-8
hospitalization and treatment, 2-5, 4-5—4-7
medical laboratory, 4-20—4-21
patient evacuation and medical regulating, 2-4, 4-3—4-4
preventive medicine, 2-6, 4-8, 4-9*a*, 4-10
veterinary, 2-8, 4-11—4-12
General Services Administration, B-3*a*
Geneva Conventions, 1-10, 3-11*a*(4), A-2*b*
goals
combat health support, N-19*b*
dental, 4-14*b*
national, 3-6*b*(2), 3-11*b*(3), 4-8*b*
objectives, 3-11*b*(3), 4-8*b*
government-owned animals. *See* veterinary services.
health. *See also* command surgeon.
care program development, 3-6*b*, 3-11, 4-6*e*(3)
care resources, 3-6*a*(3)
education, 1-6*a*, 3-4*a*(2), 3-11*a*(4), 4-6, E-1*b*
language requirements, 3-4*a*(2), D-5*c*
morbidity and mortality rates, 3-6*a*(3)

health (*continued*)
needs, 3-6*a*(3)
primary health care, 3-4*b*, 3-6*a*(3)
screening, G-2*b*
status of population, 3-6*a*(3)
hospitalization
afloat, 1-7*b*, 2-2*a*
allies, 3-9*a*(3)(*b*)
civilian hospitals, 3-3*a*(3), 4-4*b*(1) and *d*, 4-6*b*(3), K-3*a*
coalition forces, 3-9*a*(3)(*b*)
combat support hospital, 2-3*a*, 3-3*a*(3)
consultative services, 4-6, 4-7*c*
coordination, 3-9*a*(3)(*b*)
direct patient care, 4-6, 4-7*c*
domestic support operations, 3-3*a*(3)
eligibility of care, B-6
field hospital, 2-3*a*
forward surgical team, 2-3*a*
general hospital, 2-3*a*
host nation, 3-6*a*(3), 4-7*c*
host nation military, 3-11*b*(4)
location, 3-2*c*, 3-8*d*(2), 3-9*b*(3), 4-5
Medical Force 2000, 2-3*a*
Medical Reengineering Initiative, 2-3*a*
medical treatment, 4-7*f*
medical treatment facilities/stations, 1-7*b*, 2-4*c*, 3-8*d*(2), 4-3, 4-4*a*(2), 4-7*e*, 4-20, B-6, J-4, K-3*a*
multinational operations, D-6*b*
National Defense Medical System, 4-4*b*(4)
noncombatant evacuation operations, 3-2*c*
nutrition support, 4-6*b*(1)
outside operational area, 4-7
peace support operations, 4-7*f*
requirements, 3-8*d*(2)
site selection, C-6*l*
special operations forces, N-10, N-22*b*
stress control, 4-16*d*
support base, 2-4*a*
host nation. *See also* hospitalization; mental health.
availability of support, 1-4*b*, 2-4*a*
citizens, 3-2*a*
civilian medical/veterinary programs, 1-2*b*, 4-10*g*(2), 4-12*g*(3)(*a*)
civilian population, 1-6*a*, 3-6*a*(3) and *b*(2), 4-10*g*(2), 4-12*g*(3), 4-15*b*
consultation programs, 3-6*b*, 4-6
coordination with, 3-6*b*(3), P-1*a*
health care delivery system, 3-6, M-1

host nation (*continued*)
identifying health needs, 3-11*b*(3)
information source, 3-6*a*(1)
legitimacy, 1-3*a*(3), 3-11*b*(1)
medical community, 1-5*b*(2)
medical evacuation, 1-7*b*
medical infrastructure, 1-2*b,* 1-6*a*, 3-6*b*(5), 3-11*b*, N-7*e*
medical treatment, 3-12*b*(5)
mental health, 4-16*b*
military, 1-6*a*, 3-5*c*, 3-6*b*(2), 3-11*b*(4), 4-10*g*(1), 4-15*b*(1)
nurse practitioner, 3-6*b*(5), 4-6*c*
resources, 1-7*b*, 3-11*b*(2)
stability, 3-6*b*(2), 4-16*b*
status of public health services, 3-6*a*(3)
training, 1-6*a*, 3-5—3-6, 3-11*b*(3), 4-6*a*(1), N-7*a*(1)
visibility, 4-15*b*(1)
withdrawal of support, 3-6*b*(6), 3-11*b*(2), 4-10*g*(1)(*b*)
immunizations. *See* preventive medicine.
insurgency
definition, 3-11*a*
legal authority, 3-11*a*, 4-10*f*
medical infrastructure, 3-11*a*(4), 4-7*g*
mental health, 4-17*c*
mobilization, 3-11*a*
preventive medicine support, 4-10*f*
quality of life issues, 3-11*a*(4)
training, 4-10*e*
unconventional warfare, 3-11*a*(5)
interagency operations
combatant commander, B-5
combat health support implications, B-6
coordination, B-6
general, B-1
military effort, B-5
operations outside the United States, B-4
operations within the United States, B-3
planning, B-6
special operations forces, N-20*a*
standing operating procedure, B-6
training opportunities, I-8*d*
unity of effort, 1-3*a*(2), K-1*b*
joint operations, 2-2*a*, 3-4, 3-10*b*(2), 4-2*a*, N-4*a*, N-20*a*, P-1*a*
laboratory, 1-7*b*, 3-8*d*(2), 4-12*g*(3)(*e*), 4-20—4-21, J-5*a*(2), N-7*a*, N-15
language requirements, 3-4*a*(2), 3-5*c*, 4-2*a,* P-4*b*
Law of Land Warfare, 1-10

legal aspects, 3-6*b*(4), 3-11, 3-12*a*(4), 4-2*d*, 4-7*f*, 4-10*f*, 4-18*c*, B-2, B-6
lines of communications, 1-4, 3-9*b*(3), N-22*a*
logistics preparation of the theater, 1-4
main support medical company, 2-3*a*
malpractice liability, 4-2*d*
mass casualties. *See also* medical (patient) evacuation.
  area security, J-2*a*(2), J-4*a*
  augmentation, J-5*a*(3)
  combatting terrorism, 3-8*d*(2), 4-7*e*
  communications, J-2*a*(2), J-4*b*, J-5*a*(2)
  control element, J-2*a*(2), J-4, J-5*a*(2)
  coordination, J-4
  definition, J-1
  description, J-1—J-2
  disaster relief, 3-3*a*(3), 4-4*e*
  domestic support operations, 3-3*a*(3)
  establishing station, J-2*a*(2), J-5
  layout, J-5*a*(2) and *b*
  limiting access, J-2, J-4*a*
  litters, J-2
  litter stands, J-5*a*(1)
  management, 3-3*a*(3), 3-11*a*(4), 4-7*e*, J-2, J-5*a*(2)
  messengers, J-2*a*, J-4*b*, J-5*a*(2)
  nonmedical personnel, J-2*a*, J-4*b,* J-5*a*(2)
  nonmedical transportation assets, J-5*a*(1), J-6
  nuclear detonation, J-2, J-3*b*
  outdoors, J-5*c*, J-7
  patient remains, J-7
  personnel orientation, J-2*a*(2)
  personnel pools, J-5*a*(2)
  plan, 3-9*a*(3)(*b*), 4-7*e*, J-2*a*, J-5*a*(2), J-6
  rehearsals, 2-2*b*, 3-8*e*(1), J-2*a—b*
  route markings, J-2*a*(2), J-5*a*(2)
  situation updates, J-2*a*(2), J-5*a*(2)
  tactical standing operating procedures, P-6*k*(2)(*b*)
  traffic pattern, J-2*a*(2), J-5*a—b*
  treatment, N-21*c*
  triage area, J-2*a*(2), J-5*a*(2)
  triage (sorting), J-3, J-5*a*(1)
meals, ready-to-eat, 4-9*c*(3)(*b*), I-6*a*(1)
Medical Capabilities Study, 1-5*c*
medical (patient) evacuation
  adverse terrain, 3-8*b*(2), 4-4*e*
  air ambulances, 2-4*e*, 3-3*b*, 3-12*b*(2), 4-4*b*, J-6
  aircraft/vehicles of opportunity, 2-5, 4-4*d*

medical (patient) evacuation (*continued*)
ambulance exchange point, 3-9*b*(3)
ambulance shuttle system, 3-9*b*(3), 3-12*b*(3)
ambulance turnaround, 3-12*b*(3), C-6*l*
assets, 2-4*e*
attacks and raids, 3-12
availability, 2-5, 4-4*a*
backhaul, 2-5, D-6*a*
battlefield rules, 1-9*b*
combatting terrorism, 3-8, 4-7*e*
command surgeon's responsibility, 1-7
communications capability, 3-3*a*(4), 4-4*a*
coordination, 1-7*b*, 2-3*b*, 2-4*b,* 3-9*a*(3)(*b*), 3-12*a*(5), 4-4*a*, D-6*a*, N-9
counterdrug operations, 3-7*b*
delays, 2-5, C-6*h*
diplomatic flights, 3-9*a*(3)(*b*)
disaster relief, 3-3*a*(3)
domestic support, 3-3*a*(3), 4-4*b*
en route medical care, 1-9*b*, 2-5, 4-4*a*(2), 4-4*e*, J-6, N-9
evacuation policy, 2-4*a*, 3-9*a*(1), 3-10*b*(1), 4-7*f*(2), N-9
factors, 2-4*a*
from Echelon II, 2-4*d*
from Echelon III, N-9
hostile fire, 3-8*d*(2), 4-4*e*
humanitarian assistance, 4-4*c*
insurgents, 3-11*a*(5)
landing zone, J-5*a*
litter teams, 3-12*b*(3), J-5*a*(1)
loading patients, 2-2*a*, J-2*b*(2)
manual carries, 3-12*b*(3)
mass casualty situations, J-6
Military Assistance to Safety and Traffic Program, 3-3*b*, 4-4*b*(1)
military operations on urbanized terrain, 3-12*b*(3)
multinational operations, D-6*b*
noncombatant evacuation operations, 3-2, 4-4*a*
nonmedical transportation assets, 3-12*a*(5), 4-4*e*
nontransportable patient, 2-3*a*, 3-2*c*
outside of area of operations, 2-4*a,* 4-4*b*(4) and *d*, 4-6*a*(2), 4-7*e*(2) and *f*(2)
patient/casualty collecting point, 3-9*b*(3), 3-12*b*(3)
patient flow, 2-4*b,* 4-4*b*(5), C-6*l*, N-19*d*
property exchange, D-6*a*
requirements for, 3-9*b*
rescue hoist, 3-12*b*(2), 4-4*b*(2)
rescues, 3-3*b,* 3-12, 4-4*b*(2) and *d*
special operations forces, 3-11*a*(5), N-9, N-22—N-23

medical (patient) evacuation (*continued*)
specialty response team, I-5*c,* I-10
stabilization of patients, 2-3*a*, 2-4*a*, 3-2*c*, 4-4*a*, 4-7*e*(2)
tactical standing operating procedures, P-1—P-3, P-5—P-6
to host nation facility, 3-12*b*(5)
transporting medical personnel, 4-4*d*
Medical Force 2000. *See* hospitalization.
medical intelligence
analysis, I-14*a*
assessment, 1-5*b*
channels, 1-5*a* and *d*
collection, 1-5*b*(1), 3-8*b*
command surgeon, 1-7*b*
definition, 1-5*b*(1)
dental, 4-14*a*
Disease Occurrence Worldwide, 1-5
health information, 1-5*b*(1)
Medical Capabilities Studies, 1-5*c*
reporting, 1-5*g*
requirements for, 1-7*b*
special operations forces, N-7*a*, N-13, N-23*c*
update, 2-2*a,* 4-1
medical mission reconnaissance checklist, M-1—M-2
Medical Reengineering Initiative. *See* hospitalization.
medical regulating
coordination, 2-4*c*, 4-4*a*(2)
DD Form 600, 2-4*c*
DD Form 601, 2-4*c*
DD Form 602, 2-4*c*
general, 4-4
Global Patient Movements Requirements Center, N-9
multinational operations, D-6*b*
noncombatant evacuation operations, 4-4*a*(2)
office, 2-4*c*, 4-4*a*(2)
Theater Patient Movements Requirements Center, 2-4*c*, 4-4*a*, N-9
medical threat
assessment, 1-5, 1-8*c*(1), 3-2*c*, 3-10*b*(1), 4-9*a*, 4-10*e*, E-1*b*
attacks and raids, 3-12*a*(2)
countering, 1-2*b*, 1-8*c*(1), 2-6, 3-9*a*(3), N-23*c*
dental support, 4-15*b*
disasters, 1-5*e*, 4-7*b*(1)
disruption of industrial operations, 1-5*b*
environmental hazards, 1-5*a*
infectious (communicable) diseases, 1-5*a—b*
information, 1-5*b*(1), I-14*a*

medical threat (*continued*)
intelligence preparation of the battlefield, 1-5*g*
military operations on urbanized terrain, 3-12*b*(1)
nuclear, biological, and chemical, 1-5*b* and *e*, 4-16*a*
outside continental United States, 4-9*b*(1)
peace support operations, 3-9*a*(3) and *b*(3)
preventive medicine, 4-8, 4-9*a*, I-11, N-7*a*
reporting, 2-6
sources, 1-5*a*
special operations forces, N-13, N-23*c*
stress threat, 1-5*f*, 4-16*a*
tactical standing operating procedure, P-4*b*, P-6*d*
update, 2-2*a*
within the continental United States, 1-5*b*(1)
medical treatment. *See* advanced trauma management; emergency medical treatment; hospitalization; nuclear, biological, and chemical considerations.
medical treatment facilities. *See* hospitalization.
mental health
augmentation, 4-7*f*(2), I-13*c*
battle fatigue, 1-5*f*, 3-12*a*(6), 4-16*a*, 4-17*a*, Appendix O
by phase of the operation, Appendix O
casualties, 2-9, 4-16*c*
chronic mental health conditions, 4-6*a*(1)
combat health support plan, F-13
combat stress control, 1-7*b*, 4-16*c*
combat stress control estimate, F-6
combat stress control teams, 4-6*a*(2), 4-17*a*
combatting terrorism, 3-8*d*, 4-17*a*
command emphasis, 2-9
debriefings, 3-8*d*(2), 3-12*a*(6), 4-17, I-13, Appendix O
disaster relief, 3-3*a*(3), 3-4*a*(2)
holding capability, 2-9
host nation needs, 4-16*b*
misconduct stress behaviors, 1-5*f*, 2-9, 3-11*b*(4), 3-12*b*(1), 4-16*a*, 4-17*c*, Appendix O
neuropsychiatric disorders, 1-5*f*
nuclear, biological, and chemical threat, 3-8*d*(2)
peace support operations, 3-9*a*(3), 4-7*f*(2), 4-16*c*, 4-17*b*
personnel, 3-12*a*(6), 4-16*c*, 4-17, K-3*b*
post-traumatic stress disorders, 1-5*f*, 3-4*a*(2), 3-4*a*(2), 3-12*b*(1), 4-17*a*
predeployment training, 2-9, 3-4*a*(2), Appendix O
prevention, 4-17
principles, 4-17*b*
programs, 1-7*b*
screening, 4-17*b*, Appendix O
security assistance, 3-5*c*

mental health (*continued*)
specialty response team, 4-17*a*, I-13
status of, 3-6*a*(3)
stress, 2-2*a*, 2-9, 3-8*d*(1), 3-9*a*(3), 3-11*b*(4), 3-12*b*(1), 4-16—4-17
stress control measures, 3-4*a*(2), 3-8*d*(2)
support, 3-3*a*(3)
surveys, 4-17*b*, I-13*c,* K-3*b*
medical (combat health support) units, 2-3*c*, 2-7*a,* 3-9*a*(3), 3-11*b*(4), 3-12*b*(1), A-4*c*, C-6*e*
Military Assistance to Safety and Traffic Program. *See* medical (patient) evacuation.
military operations on urbanized terrain, 3-9*b*(3), 3-12*b*
mission, enemy, terrain, troops, and time available, 3-12*a*(2), 4-7*a*(2), 4-19*c*
multinational/combined operations
alliances, D-2*a*, D-3*a*
coalitions, D-2*b*, D-3*b*
general, 2-2*a*, 3-4, 3-10, 4-2*a*, D-1, N-4*a*
integrated command structure, D-3*a*(2)
interoperability, D-4
lead nation command structure, D-3*a*(3) and *b*(2)
liaison team, D-4*a*
parallel command structure, D-3*b*(1)
rationalization, D-4
standardization, D-4*b*
tactical standing operating procedure, P-1
National
Command Authorities, 3-10*a*, 3-11, N-6*b*
Communications System, B-3*a*
Disaster Medical System, 3-3*a*(3), 4-4*b*
Interagency Fire Center, B-3*a*
Medical Chem-Bio Advisory Team, I-12
objectives, 1-2*a*—*b*, 3-1
Oceanic and Atmospheric Administration, B-3*a*
Weather Service, B-3*a*
nation assistance
combat health support role, 1-2*b*
dental support, 4-15*b*(1)
general, 3-11*b*(3)
peace support operations, 3-9
program development, 4-6*a*(1)
support to, 4-12*g*
news media (press coverage), 1-10*b*, 3-11*d*, G-1, G-3*a*
noncombatant evacuation operations. *See also* medical (patient) evacuation.
availability of medical resources, 3-2*b*
coordination, 4-4*a*(2)
definition, 3-2*a*
evacuation notice, 4-7*a*(2)

noncombatant evacuation operations (*continued*)
evacuation platforms, 4-4*a*(2)
factors, 3-2
force, 4-4*a*(2)
health needs of evacuees, 3-2*b*
hostile environment, 3-2*a*, 4-4*a*(1)
intermediate staging base, 4-4*a*, 4-7*a*
level of hostilities, 3-2*a*
permissive environment, 4-4*a*(1), 4-19*a*
preventive medicine support, 4-10
safe haven, 3-2*a*, 4-4*a*, 4-7*a*
security, 3-2*c*
task organization, 4-21*a*
uncertain environment, 4-4*a*(1)
veterinary support, 4-12*a*
nonphysician health care practitioners
community health nurse, 4-6*c*, 4-14*d*, K-3*b*
dietitians, 3-3*a*(3), 4-6*b*, K-3*b*
nurses, 1-7*b*, 3-3*a*(3), 3-6*b*(5), 3-11*a*(4) and *b*(4)
occupational therapy, 3-3*a*(3), 3-11*b*(4), 4-6*a*, 4-7*f*(2), K-3*b*
optometry, 4-6*f*
pharmacy, 4-6*d*
physical therapy, 3-3*a*(3), 3-11*b*(4), 4-6*a*, 4-7*f*(2), K-3*b*
radiology, 4-6*e*
North Atlantic Treaty Organization, D-2*a*
nuclear, biological, and chemical considerations. *See also* biological warfare agent; chemical warfare agent; weapons.
biological, G-2
casualties, G-6
civilian disasters, G-6
collective protection, G-3*c*
decontamination, G-1*b*, G-4*c*
defense, 3-8*e*(3), G-3*c*
detection, G-1
identification, G-1*b*
mission-oriented protective posture, 4-16*a*, C-6*e*, G-3*c*, G-5
nuclear, G-4
operations under, G-5
patient decontamination, C-6*l*, G-1*b*, G-3*d*
prophylaxis, G-1*b*
protection, G-1*b*, G-3*c*
reporting, G-2*c*
stress, 4-16*a*
treatment, G-3*d*, G-5
Nuclear Regulatory Commission, B-3*a*

nursing. *See* nonphysician health care practitioner.
nutrition, 1-7*b,* 3-3*a,* 3-11, 4-6*b*, 4-10*g*(2)(*b*)
Occupational Safety and Health Administration, B-3*a*
occupational therapy. *See* nonphysician health care practitioner.
Operation
  Desert Storm, D-1
  Joint Endeavor, Appendix O
  Just Cause*,* 1-9*b*
  Urgent Fury, 2-2*a*
operations security, 1-8*d*(1), 2-2*a*, 3-8*d*(2), A-2*c*, N-10, N-22*b*
Pan American Health Organization, 3-11*a*(4)
patient
  collection, 3-9*b*(3)
  densities, 3-9*b*(3)
  holding, 2-3*a*, 2-5
  stabilization, 2-3*a,* 2-4*a*
  work load, 2-4*a,* 3-9*b*(3), 3-10*b*(1), 3-12*b*(5)(*c*), 4-6*a*(2), 4-7*b*, D-6*b*, K-3*b*
peace support operations. *See also* nation assistance.
  Army Medical Department role, 3-9*a*
  definition, 3-9
  escalation of hostilities, 3-9*a*(3)(*b*)
  evacuation policy, 3-9*a*(1)
  mental health activities, 3-9*a*(3)
  neutrality, 3-9*a*(2)
  peace enforcement operations, 3-9*b*
  peacekeeping operations, 3-9*a*
  planning considerations, 3-9*a*
physical therapy. *See* nonphysician health care practitioner.
planning. *See also* command surgeon; contingency plans; disaster relief/assistance; mass casualties; medical (patient) evacuation; nuclear, biological, and chemical considerations; preventive medicine support.
  advance party, 1-8*c*
  attacks and raids, 3-12*a*
  availability of resources, 1-4*a*, 1-8, 3-3*a*(3)
  battle plans, 3-1
  combat health support, Preface, 1-5*b*(1) and *c*, 4-1, 4-11*a*, N-8, N-21*c*
  combat health support planner, 1-1, 1-5*e*, 1-6*b*, 1-8*b*, 2-3*c*, 2-4*a*, 2-8*b*, 3-3*a*(3), 3-8*d*(2), 3-9*a*(3)(*b*), 3-10*c*(2), 3-12*a*, 4-4*d*, 4-15*b*(2), 4-18*a*, D-5*f*, F-1, F-8, J-2
  commander, 1-4*a*, 2-5, 4-7*f*(1)
  command surgeon, 1-7—1-8, 4-4*b*(5), 4-7*f*(1), 4-8
  coordination, 2-1*b*, 3-11
  determining requirements, 1-8*c*
  disaster relief*,* 3-3*a*
  duration of operation/mission, 1-6*c*, 2-4*a*, 3-2*a*, 3-3*a*, 3-9*b*(2), 3-10*b*, 3-12*b*(5)(*c*), 4-7*f*(2), 4-12*h*, 4-19*e*, 4-20, I-6*a*, I-14*b*
  economic status, 1-6*c*

planning (*continued*)
estimate, 1-7*b*, F-1—F-14
flexibility, 1-8*b*, 2-1*b*, 3-11, 4-4*d*, 4-18*a*
force protection, A-4
interagency operations, B-6
interoperability, 1-8*d*
involvement, 2-1*b*
laboratory services, 1-7*b*
level of, C-6*m*
level of hostilities, 1-6*c*, 2-4*a*, 3-2*a*, 3-9*b*(2), 3-10*b*, 4-7*f*(2), 4-19*e*
logistics preparation, 1-4
medical evacuation, 2-5, 4-4*d*
medical mission reconnaissance checklist, M-1—M-2
medical regulating, 4-4*b*(5)
military operations on urbanized terrain, 3-9*b*(3), 3-12*b*
mission, 3-10*b*
nursing services, 1-7*b*
nutrition, 1-7*b*
operations plan, 1-7*b*, 2-2*a*, 3-8*d*(2), 4-11*a*, D-6*f*, F-8—F-14
peace enforcement operations, 3-9*b*
peacekeeping operations, 3-9*a*
political concerns, 1-6*c*, 3-1, 3-2*a*
problem solving, 1-8*b*
process, 1-8*c*
rear area protection, 1-7*b*
rehearsal, 2-2*b*, I-8*c*
rescue operations, 3-12
risk assessment, C-6
show of force, 3-10
size of
force, 3-2*b*—*c*, 3-9*b*, 3-10*b*(1)
medical element, 3-9*a*, 3-10*b*(1), 4-5, 4-6*a*, 4-19*b* and *e*
special operations forces, N-8
type of operation, 1-6*c*
veterinary support, 2-8*c*, 4-11*a*
preventive medicine. *See also* diseases and injuries.
acclimatization, 2-6, 3-12*a*, 4-9*d*(1), C-6*j*
arthropodborne diseases, 4-9*b*
assessments, 1-5*b*(2), 3-3*a*(3)
attacks and raids, 4-10*h*
breeding grounds, 1-5*b*, 3-3*a*(3), 3-12*b*(1)
chemoprophylaxis, 2-2*a*, 2-6, 3-8*d*(2)
combat health support operations plan annex, F-11
command emphasis, 3-9*a*(3), 4-10*e*
communicable (infectious) diseases, 1-5*a*—*b*

preventive medicine (*continued*)
contamination of food and water, 1-5*b*, 3-12*b*(1), 4-9*c*(4), 4-10*d*, G-2*a*, G-3*a*, G-4*b*
decontamination, 4-10*d*
disaster relief, 3-4*a*, K-3*a*
domestic support operations, 4-10*b*
endemic diseases, 2-6, 3-3*a*(3), 3-6*a*(3), 4-9*b*(2)(*a*), D-6*d*
environmental
contamination, 2-6
hazards, 1-5*b*, 3-3, 4-9*d*(3)
injuries/affects, 4-8*a* and *d*, 4-9*d*
epidemic diseases, 2-6
equipment and supplies, 2-6, 4-9*c*(6), I-7*e*
estimate, F-4
field sanitation, 2-6, 3-3*a*(3), 3-8*d*(2), 3-11*b*(4), 4-8*a*, 4-9*c*(6), 4-10*b* and *f*, B-6, D-6*d*, G-2*b*
field sanitation teams, 2-6
foodborne and waterborne diseases, 2-6, 4-9*c*
general, 4-9*a*, Appendix O
ice, 3-3*a*(3), 4-9*c*(3)(*c*), G-2*a*
immunizations, 2-2*a*, 2-6, 3-8*d*(2), 3-11*b*(4), G-2*b*, I-5*b*(1), N-20*c*
in military operations on urbanized terrain, 3-12*b*
inspections, 2-6, 3-3*a*(3), 4-11*c,* D-6*d*, G-2*b*
in support of an insurgency, 3-11*a*(4), 4-10*e*
measures, 2-2*a*, 3-3*a*(3), 3-5*b*, 3-9*a*(3)(*b*), 3-11*a*(4), 3-12, 4-8, 4-9*b*—*c,* 4-10*e*, I-7*e*, N-12, N-23*c*
medical mission reconnaissance checklist, M-1—2
multinational operations, D-6*d*
noncombatant evacuation operations, 4-10*a*
occupational hazards, 4-9*d*(3)
peace support operations, 3-9*a*, 4-7*f*(2), 4-10*e*
personal
hygiene, 2-6, 3-3*a*(3), 3-6*a*(3)
protective measures, 3-3*a*(3), 3-8*b*(2), D-6*d*
personnel, 1-5*b*(2)
pest management, 2-6, 3-4*a*(2), 3-9*a*(3)(*b*), 3-12*b*(5)(*c*), 4-10*b*(1) and *g*(2)(*b*), D-6*d*
physical training, 2-6
planning for, 1-7*b*, 3-9*a*(3), 4-8, 4-10*g*
prophylaxis, G-2*b*
public works, 3-3*a*(3), 4-10*b*(1)
refugee camps, 3-4*b*, 3-12*b*(5)(*c*)
sanitation, 1-2*b*, 1-5*b*, 2-6, 3-3*a*(3), 3-4*b*, 3-6*a*(3), 3-9*b*(3), 3-11*a*(4), 4-9*b*, 4-10*a*, C-6*i*
security assistance mission, 3-5*c*
sleep plan, G-2*b*
special operations forces, N-7*a*, N-12
specialty response teams, I-2*a*
standing operating procedures, P-6*k*
support, 1-6*a*

preventive medicine (*continued*)
training, 3-3*a*(3), I-11*d*
transferring diseases, 3-2*c*, 4-10*a*
waste disposal, D-6*d*, K-3*a*
water
discipline/consumption, 2-6, 4-9*d*, G-2*b*
sources, 3-3*a*(3), 3-4*b*, 3-8*d*(2), 4-9*c*, 4-11*c*, G-3*a*
supplies, 3-3*a*(3), 3-12*b*(5)(*c*), D-6*d*, G-4*d*, K-3*a*
treatment, 4-9*c*(3)(*c*)
principles
applicability, 1-3*a*
legitimacy, 1-3*a*(3)
objective, 1-3*a*(1)
of war, 1-3*a*
perseverance, 1-3*a*(4)
restraint, 1-3*a*(5)
security, 1-3*a*(6)
unity of effort, 1-3*a*(2)
Professional Officer Filler System, I-4*c*
psychological operations, 4-12*g*(3)(*a*), N-4*a*(1), N-6*e,* N-7*d*
quality of life, 3-5*b*, 3-11*a*(4), 4-6*a*(1)
refugees. *See* civilians; preventive medicine.
Regional Medical Command, I-1, I-2*a*(1), I-3*a*, I-12
rehabilitation support
general, 1-7*b*, 3-11*b*(4), 4-6
guidance, 3-11*a*(4)
orthotic devices, 3-6*a*(3)
prosthetic devices, 3-6*a*(3)
research and development. *See* command surgeon.
return to duty, 1-9*b*, 4-6*a*(2), N-11
risk assessment
approach, C-2*a*, C-4
factors, C-6
five steps, C-2*b*
general, C-1
levels of risk, C-5
process rules, C-3
rules of engagement, 1-3*a*(5), 1-6*c*, 1-10*d*, 2-9, 4-16*a*, P-3*b*
S2 (Intelligence Officer, [US Army]), 1-5*c*
sanitation. *See* preventive medicine.
security assistance
foreign internal defense augmentation forces, 3-5*c*
Foreign Military Sales Program, 3-5*a*
general, 3-5*a*
International Military Education and Training Program, 3-5*a*

security assistance (*continued*)
mission, 3-5*c*
organization, 3-5*c*, 3-6*b*(3)
Security Assistance Training Program, 3-5*a*
unified command, 3-5*c*
separate brigade, 2-3*a*
show of force, 3-10
special operations forces. *See also* United States Navy.
Army special operations forces, N-2, N-5*b*, N-6, N-9
civil-military operations, N-20*b*
collateral activities, N-4*a*(2)
command and control, N-5
Commander in Chief, N-5
components, N-2
conventional combat health support, 4-7*g*, N-7
coordination with, 3-6*b*(3), N-9
direct action, N-4*a*(1), N-6*b*, N-18, N-22
foreign internal defense, N-18
joint special operations area, 3-11*a*(5)
medical evacuation, 3-11*a*(5), N-7*c*, N-9, N-19*d*
missions, N-4*a*(1)
Ranger regiment, N-6*b*, N-7*b*
special forces group, N-6*a*, N-7*a*
special operations aviation, N-6*c*, N-7*c*
special reconnaissance, N-18, N-23
unconventional warfare, 3-11*a*(5), N-4*a*(1), N-15—N-16, N-19, N-21*b*
veterinary training, 4-12*g*(2)(*b*)
specialty response teams
administrative support, I-6
burn, I-2*a*(2), I-5*a* and *c*, I-10
chemical/biological, I-2*a*(1), I-12*a*
communications, I-6*a*(2)
composition and equipment, I-4, I-7
deployability, I-5
food safety, veterinary preventive medicine, and animal health care, I-2*a*(1), I-5*a*, I-15
general, 2-2*c*, 3-3*a*(3), 3-4*a*(2), 3-8*d*(2), I-1
preventive medicine threat assessment, I-2*a*(3), I-11
request for assistance, I-3
responsibilities, I-2
stress management, I-2*a*(1), I-13
telemedicine, I-2*a*(1), I-14
trauma/critical care, I-2*a*(1), I-9
stability and support operations. *See also* disaster relief/assistance; refugees; United States Agency for International Development.
conflict, 1-1, 1-2*a*

stability and support operations (*continued*)
constraints, 1-3*a*(5)
cultural influences, 1-6*c*, 3-11*b*(2), 4-10*g*(2)(*a*), 4-16*b*, 4-19*c*, D-5*e*, D-6*d*
definition, 1-2*a*
economic status, 1-6*c*, 3-11*b*(2), 4-10*g*(2)(*a*), A-4*c*
environment, 4-10*b, e—f,* and *h*
general, Preface
peace, 1-1
political considerations, 1-6*c*, 4-10*g*(2)(*a*), A-4*c*
religious concerns, 1-6*c*, D-5*e*, D-6*d*
unique setting, 1-8*b*
stability and support operations participants. *See also* civilians; disaster relief/assistance; host nation; United States Agency for International Development.
allies, 1-6*a*, 1-7*b*, 3-9*a*(3)(*b*), 4-7*f*(1), 4-19*c*
civil affairs units, 3-6*a*(1)
civilian noncombatants, 3-2*a*
coalition forces (partners), 1-6*a*, 1-7*b*, 3-9*a*(3)(*b*), 4-7*f*(1)
coordination, 1-7*b*, 3-9*b*(3)
defense attaché, 3-6*a*(1)
Department of Defense contractors, 1-6*a*, 3-9*a*, 4-2*d*, 4-7*f*(1)
economic status, 1-6*c*
general, 2-3*a*
host nation, 3-2*a*
non-Department of Defense agencies, 3-3*a*(3), 4-19*c*, B-1*a*
nongovernmental agencies, 4-2*a*, B-4*b*, P-3*b*
other Services, 3-9, 3-12*a*(5), 4-7*f*(2)
private volunteer organizations, 1-3*a*(2), B-4*b*, P-3*b*
religious groups, 1-3*a*(2), 4-14*d*, 4-19*c*, B-1*b*
United Nations personnel, 1-6*a*, 3-9*a*, 4-2*d*, 4-7*f*(1)
United States
citizens, 3-2*a*
Forces, 3-2*a,* 4-9*b*(2)(*b*)
governmental agencies, 1-3*a*(2)
government civilian employees, 1-6*a*, 3-9*a*, 4-7*f*(1), I-4*b*
military dependents, 3-2*a*
standing operating procedure
clinical, P-1*a*
forms and formats, 4-2*b*, P-3
specialty response teams, I-4*a*
tactical, P-1—P-2, P-5—P-6
tables of organization and equipment, Preface
task organization
combat health logistics, 4-19*b*(1)
contingency operations, 2-3
dental, 4-15*b*(2)

task organization (*continued*)
hospital, 4-5
joint task force, 3-5*c*, 4-2*b*
medical force package, 4-7*b*(1)
peacekeeping operations, 3-9*a*(3)(*a*)
resources, 4-1, 4-7
surgical capability, 2-5
tailoring, 2-3*c*, 3-9*a*(3), N-21*b*
threat. *See also* medical threat.
assessment, 1-3*a*(6), 3-8*b*
combatting terrorism, 3-8, A-1
countering, 1-2*b*, A-1
directed energy, 1-5*e*
general, 1-2*b*
nuclear, biological, and chemical, 1-5*b* and *e*, 4-16*a*, D-5*f*, G-1
special operations forces, N-3
terrorist, 1-5, 3-9*a*(3)(*b*), 4-10*d*
Title 10, United States Code
excess nonlethal supplies for humanitarian relief, L-4
foreign disaster assistance, L-3
general, 3-6*c*
humanitarian assistance, L-1, L-4—L-5
special operations, N-4*a*(1)
transportation for humanitarian relief supplies, L-2
training
Army Nurse Corps, 3-11*a*(4)
civilians, 3-3*b*
combat health logistics, 4-19*d*(2)
combatting terrorism, 3-8*e*(3)
first aid, 3-11
health care professionals/medical personnel, 3-11*a*(4), 4-6, 4-7*g*
in an insurgency, 3-11*a*(4), 4-7*g*
individual, G-3*c*
medical readiness, 1-6*a*
medical readiness training exercises, 1-6*a*
mental health, 2-9, 3-5*b*, I-13*d*
military and paramilitary forces, 1-6*a*
military operations on urbanized terrain, 3-12*b*
mobile training team, 3-5*c*
nuclear, biological, and chemical, G-1*b*, G-3*c*, I-15*c*
orientation, 3-8*e*(2)
package, 3-5*b*
predeployment, 2-9, 3-4*a*(2), 4-10*e*, N-21*c*
preventive medicine, 3-5*b*, 4-10*g*(1)(*b*)
Special Forces, N-7*a*(1)

training (*continued*)
specialty response teams, I-8, I-15*c*
stress management, 2-9
unit, G-3*c*
veterinary support, 4-11*c*, 4-12*g*
triage, 3-11*a*(4), 4-7*b*(1), G-6, J-3, J-5
triage categories
DELAYED, J-3*b*(2), P-6*k*(2)(*b*)
EXPECTANT, J-3*b*(4), P-6*k*(2)(*b*)
IMMEDIATE, J-3*b*(1), P-6*k*(2)(*b*)
MINIMAL, 3-8*e*(4), J-3*b*(3), J-5*c*, P-6*k*(2)(*b*)
troop ceiling, 2-4*a*, 2-9, 4-7*f*(2), 4-10*e*
United Nations High Commissioner for Refugees, B-4*b*
United States
Agency for International Development
coordination, 3-6*b*(3), 4-10*c*
determining health needs, 3-6*a*(1)
disaster relief, 4-10*c*
foreign humanitarian assistance, 4-10*c*
general, B-1
veterinary support, 4-12*g*(3)
Air Force, 1-7*b*, 2-4*c* and *e,* 3-12*a*(5), 4-4*d*, 4-11*a*, 4-16*d*, 4-19*a*, I-7, N-5*b*, N-9
Ambassador, 3-6, 3-11*b*(3), 4-2*c*, B-4—B-5
Army
Center for Health Promotion and Preventive Medicine, I-1
Institute of Surgical Research, 3-3*b*, I-2*a*(2), I-10*a*
Medical Command, 1-5*b*(1), I-1—I-2, I-3*b*, I-4*a*, I-11*b*
Medical Department Activity, 1-5*b*(1), 3-3*a*(3) and *b*, 4-7*b*(1)
Medical Department medical center, 1-5*b*(1), 3-3*a*(3) and *b*
Medical Research and Materiel Command, I-1, I-12
Medical Research Institute of Chemical Defense, I-12*a*
Medical Research Institute of Infectious Diseases, I-12
Reserve, I-4*d*
Veterinary Command, I-2*a*(4)
Civil Affairs and Psychological Operations Command, 1-5*b*(1)
Forest Service, B-3*a*
Information Agency, B-3*a*
Navy
capability afloat, 1-7*b*
deck-landing certification, 2-2*a*
laboratory, 3-12*a*(5), 4-21*a*
medical evacuation, 1-7*b*, 2-4*d*, 3-12*a*(5)
mental health, 4-16*d*
special operations forces, N-5*b*
Public Health Service, 4-21*c*

United States (*continued*)
Special Operations Command, N-13
veterinary services
animal care, 1-7*b*, 3-11*a*(4), 4-11*c*, 4-12, D-6*g*
animal husbandry, 3-7*a*, 3-11*a*(4). 4-11*c*, 4-12*a*(3)
assessment, 4-12*g*
civic assistance programs, 1-7*b*, 4-12*g*(2)(*c*)
combat health support plan, F-10
combatting terrorism, 3-3*d*, 3-8*d*(2)
Commander in Chief, 4-11
coordination, 4-11*d*, 4-12*a*(3)
counterdrug operations, 3-3*d*, 3-7*a*, 4-12*d*
Department of Defense, 2-8*a,* 4-11*a*, 4-12*d*, D-6*g*
disaster relief, 4-12*b*
estimate, F-3
food
inspection, 1-7*b*, 2-8*a*, 3-3*a*(3), 4-11*c*, 4-12, G-4*c*, N-14
procurement, 3-9*a*, 3-12*b*(5)(*c*), 4-12*b*, B-6
sources, 3-8*d*(2), N-14
wholesomeness, 3-4*b*, 3-12*b*(5)(*c*), 4-11*c*, 4-12, B-6, D-6*g*, G-2*b*, K-3*a*
government-owned animals, 2-8*b*, 3-3*d*, 3-8*d*(2), 4-11*c*, D-6*g*
health status, 3-6*a*(3)
infrastructure, 4-12*g*(3)(*b*)
in support of a counterinsurgency, 4-12*g*
in support of an insurgency, 4-12*g*
livestock, 3-3*a*(3), 4-11*d*, 4-12*g*(2)(*b*), K-3*b*
long-term projects, 4-12*g*(3)(*c*)
medical mission reconnaissance checklist, M-1—M-2
military mascots, 2-8*b*, 4-11*c*, 4-12*h*
military working dogs, 2-8*b*, 3-7*a*, 4-11*c*, 4-12*g*(2)(*b*)
noncombatant evacuation operations, 3-2*,* 4-12*a*
pack animals, 4-11*c*, 4-12*g*(2)(*b*)
peace support operations, 4-12*f*
preventive medicine, 1-7*b*
privately owned pets, 3-2*c*, 4-12*a*(1), K-3*b*
quality assurance, 4-12, D-6*g*
security assistance, 3-5*c*
short-term projects, 4-12*g*(3)(*c*)
special operations forces, 4-12*g*(2)(*b*), N-14
specialty response team, I-2*a*(4)
status of, 3-6*a*(3)
support, 1-6*a*, 3-3*a*(3) and *d*, 4-12
support for insurgency and counterinsurgency, 4-12*g*
surveillance of food stuffs, 2-8*a*, 3-9*a*(3)(*b*), 3-12*b*(5)(*c*), 4-10*d*
tactical standing operating procedures, P-6*k*(2)

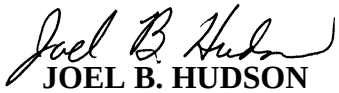
veterinary services (*continued*)
to host nation, 4-12*g*
zoonotic animal disease, 4-12*h*
war, 1-1, 1-2*a*, G-3*c*, G-4*a*
weapons
conventional, 1-5*e*
directed energy, 1-5*e*, 1-7*b*, 3-8*d*(2)
incendiary/flame munitions, G-3*b*
irritants, G-3*b*
medical effects, 1-7*b*
nuclear, biological, and chemical, 1-5*e*, 1-7*b* 3-8*d*(2), D-5*f*, G-1*a*, G-3, G-5—G-6
phosphorous compounds, G-3*b*
tactical, N-22*a*
World Health Organization, 3-6*a—b*, 3-11*a*(4), I-11*c*
wounded in action, 2-6, 4-17

FM 8-42
27 OCTOBER 1997

By Order of the Secretary of the Army:

DENNIS J. REIMER
General, United States Army
Chief of Staff

Official:



JOEL B. HUDSON
Administrative Assistant to the
Secretary of the Army
03921

DISTRIBUTION:

Active Army, Army National Guard, and U. S. Army Reserve: To be distributed in accordance with initial distribution number 114930, requirements for FM 8-42.

PIN: 045849-000